11-08357 Antonio Williams Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011 38001

Antonio Williams Antonio Death Prince George's Hospital Antonio Death Antonio De	od. Inside City Limits Yes 2 No tates Indian, Black, can ican
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Social Security Number 6. Sex 7. Age (in yrs. last birthday) 1	ny) DC Od. Inside City Limits Yes 2 No record No re
Director State The part of the part o	ny) DC Od. Inside City Limits Yes 2 No record No re
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The state of Funeral Service Licensee 1	
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Physician 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Agricultural list only one each line.	Maryland
Physician 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Agricultural list only one each line.	Inc.
failure List only one course on each line	20019
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the contribution of the conditions of the complete	
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24a. Was an autopsy prior to complete to the c	2 No
25. Was case referred to medical examiner? Hospital: 1 Inpution 2 Properties 3 Prop	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: 27. Manner of Death (Month, Day, Year) 28. Date of Injury (Month, Day, Year)	
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 37 pm 1 Yes 2 No subject assaulted	
Fending Investigation fd 10-27-11 fd 06:37 pm 1 Yes 2 No Subject assaulted Subject Subject	2 1 1 1 2 2 2
24a. Was an autopsy prior to complete the proof of the part of the	toute Number, City
Northeast washington	as St.
회 및 학교 😭 😭 😭 👊 one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau	as St.
and manner stated. 29c. License number 29d. Date signed (Month, D	
O.C.M.E. November 8, 2011	use(s)
30. Name and address of person who completed cause of death (Item 23a)	use(s)
Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	use(s)
State 31. Date filed (Month, Day Year) 32. Registrant Signature Registrar NOV 18 200 Account A	use(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 10, 2011 13:51 Queenie A. Worthy Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. 1 □ M 2 🛂 F **Director** 245-32-2595 Yrs. 92 July 14, 1919 South Carolina Usual Residence of Deceder or 28a-f shov notified at show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 1101 46th Place SE 20019 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Black δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🏻 No Specify: If Yes, Give Year or Dates 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Government <u>Supervisor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Luellen Jameson Macke Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 20002 Henry Williams- Nephew 1825 Maryalnd Avenue NE Washington, DC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 <u>Fort Lincoln</u> Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, RW 4001 Benning Road NE Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate 2090d.ml Onset and Death Immediate Cause (Final 501mc Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a densequents of): cause. Enter Underlying Cause (Disease or injury that initiated events Exam Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death the hed 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 No __ Yes 1 🗌 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death within 24 hours after death.

To the Funeral Director: After t completely filled in by the funer. Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No Matural iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Day, Year)

U(N)I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38003 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Zo il Leona Joann Beasley Walker OZY 12:23 DM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WHITHOUR BUCKET HERPIAL MONTGOMER MYKEMA PARK 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 26, 1925 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🍱 F Days Hours Min. 247-26-5647 Yrs Director 86 Carolina Usual Residence of Decedent 28a-f shov 10b. County 10a State death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Hyattsville 1 X Yes 2 □ No Maryland Prince George's ò 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 20783 9272 Adelphi Road Unit 12 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 5 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 💆 No Specify: 3 Nidowed 4 Divorced "natural" Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) 12th College (1-4 or 5+) Nurse Government be filed \ Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ည Nelson Richardson Roberta Jenrette 19a. Informant's Name/Relationship (Type, Grint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 Jacquelyn C. Little -9272 Adelphi Road Unit 12 Hyattsville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Nov 2011 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Clinton, Maryland 21. Signature of Fryneral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Road NE Washington, DC 20019 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. AMERICALETINE CONCENTRICALET disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Dust to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f Yes 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown iours after death.

Peral Director: After this certificate has been si filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 🗌 Yes 25. Was case referred to medica examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 35427 11-03-2011 d address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day Ye

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Micma Park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Walker Ella Muir Octobe 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death alisbury Rehabilitation a Nursing Ctr.
Social Security Number 6. Sex 7. Age (In yrs. sest birthday) Wicomico isbur If Under 1 Year If Under 24 Hrs Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days 0972171930 220-26-8305 81 Mary Land Director Usual Residence of Decedent 28a-f short 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30412 Saxon Court 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) 12 College (1-4 or 5+) Department Manager Retail Store Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Van Muir Sr. Reba Bozman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trudy W. Tawes/daughter 231 Middle Blvd. Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Parsons Cemetery 10/31/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onsettand Death shock, or heart failure. List only one cause Adiovarculer Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Dusito (or as a consequence of) Examir as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Unknown to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 2 🗌 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNO 1 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Suursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at s after death. Certificate: 28d. Describe how injury occurred Natural 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined e Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

DHMH 17 Rev 7/2009

State

Registrar

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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2011

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

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Annie B. Wilson Wife 919 Eastern Ave. Pairmount Heights M20743 200. Location - City or Town. State 220. Method of Deposition 18 June 12 (20 Centerol Seposition) 220. Method of Deposition 18 June 12 (20 Centerol Seposition) 220. Method of Deposition 18 June 12 (20 Centerol Seposition) 220. Name and Address of Facility 220. Name	O36	ď						C	onst	ruct	ion				Helm	an		
Annie B. Wilson/ Wife 200. Place of Deposition (Name of cemetery) Date Da	5-0 led w Hygie		17. Father's Name (Fire	st, Middle,	Last)				•		18.Moth	her's Nam	e (First, Midd	le, Maide	en Surname)			
Amine B, Wilson Wife 2D Passes of Deposition (Name of ceretery). Date 2D Location - City of Town State Controlling in Controll	21 be fil ntal I										Do	ora	E. Co	lem	an			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 08 Physician/ Melvin Yudelevit November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17225 Emerson Drive Silver Spring Montgomery 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 578-34-8425 Director 1 X M 2 🗆 F 83 08/25/1928 Washington, DC or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 ☐ Yes 2 🛣 No Maryland Silver Spring Montgomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20905 17225 Emerson Drive U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian natural", or þ 1 Never Married 2 X Married 2 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3
Widowed 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within '2 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megone. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Veterans Administration Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Ann Ehrlich Harry Yudelevit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janis Yudelevit - Spouse 17225 Emerson Dr., Silver Spring, Maryland 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) Columbia Mem. Park 11/10/2011 | Clarksville, MD Sign dure of Fun Service vice see 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 4100709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Renal Cell Carcinoma Months Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): for use as the buria attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 X No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 **X** No after death.

Director: After this certificate ∣ ☐ Yes 1 Yes 2 No apletely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural 5 Pending iniury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number MDO60335 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

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#327

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Diane ANThony November 24^{Day} 2011 Year 1.50 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Northwest Hospital Randallstown Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours July 13, 1940 214 40 9810 71 **Director** Mary land 1 🗆 M 2 🍱 F 28a-f show 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Maryland Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8115K Yellow Pine Drive U.S.A. 21043 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White "natural", Specify. 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Maction 2000. 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) sales associate clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Joseph Anthony Anna Lenore Danilkevich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Prominade Lane Mt. Airy, Maryland 21771 James J. Anthony, Jr. brother 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland Nov 29, 2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Hone, P.A. rice Licensee M1270 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pancreatic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the himsel-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed 1 Yes Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Vother (Specify) Hospital 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MS Ray apalne M.D 00057465 11/24/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 203 Baltimore MD 21209 0 N.S. Rajapakse, M.D 2835 Smim AV

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monica Christine Albright November 2011 12:45 AM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death S. Paula Street 17 A Laurel Anne Arundel 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Oct. 2, 1 M 2XX Months Davs Hours 1950 Maryland Director 217-56-7368 61 Usual Residence of Decedent show 10a. State 10c. City. Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Anne Arundel Laurel 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 17 A S. Paula Street 20724 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Yes 2 X No Yes, Give ò 2 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ice Elementary/Seconday (0-12) College (1-4 or 5+) the Dreyer's Grand Cream 12th Cream Packer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental h permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ည William Wallace Albright Valeria Irmgard Zeisig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Marianne Brown/Daughter 11202 D Barnswallow Place, Waldorf, MD 20603 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 11/30/2011 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. Signature of Funeral Service Licenses M01103 313 Talbott Avenue, Laurel, MD 23a. Part V. Ent r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Interval Retween Immediate Cause (Final disease or condition Onset and Death Physician/ Breast Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Dav Year 1 Yes 2x signed by the a Yes 2xXNo P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s 1 ☐ Yes 2 🛣 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Hospital Other: ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Isabella C. Martire, M.D.

DHMH 17 Rev 7/2009

D45014

8343 Cherry Lane, Laurel, MD

NOVERBUR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charlotte Ann Brown 26. 2011 10:10 a.M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min 213-26-3429 **Director** 1 □ M 2**X** F 82 April 7, 1929 Maryland Usual Residence of Deced 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at **Funeral Director** 1 Yes 2 X No MD Baltimore Baltimore 0 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? must be n 8820 Walther Blvd Apt 4518 21234 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed Specify: 3 X Widowed 4 Divorced Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Teacher Balto Co.Public Schools Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Ment. Important: If Item 27 is marreany injury or any injury Joshua Ellsworth Pindell Delia Charlotte Ripley injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Brown Son 12 Kristal Court; Nottingham, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Atlantic Crematory 1 Burial 2 Cremation 3 Removal from State 12/2/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Fuperal Service Licensee W M01234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ METASTATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death Month Year cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≙ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Hospital or Attending Physician: The this certificate 2 🗌 No Yes 2 X No 1 🗌 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: ဂ္ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director, After (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature and tale of 29d. Date signed (Month, Day, Year)

10 1

10:10 a.m.

NOVEMBER 26,

CHARLOTTE BROWN

Registrar
DHMH 17 Rev 06-2011

State

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

31. Date filed (Menth, Day,-Year) -

2011

TIMONIUM, MD 21093

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, I

witho

VASANTDATTAMO

7 3 0 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 no mile st

32. Registrar's Signature

29c. License number

018019

MALKRITOWN

29d. Date signed (Month, Day, Year)

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NOVENSER 26,2011

21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 - For State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Baker 6:15 PM Medical 4c. County of Death
Baltmore 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death Nlanor owson Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Hours Min Director 1 🗆 M 2 🗷 F 81 er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Himore MD 1 Yes 2 No 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. 3 ₩idowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done of life. DO(NOT use retired) during most of working other than Elementary/Secondary (0-12) vurse other traumatic event, Be Name (First, Middle, Last) er's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of Dwinson 19b. Mailing Address (Street and Number or Ruryl Routh Number, City or Town, State, Zip Code) 2/239 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau tve. Woodbourner Baltimore, 20b. Place of Disposition (Name of cemetery, crematory of other p 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State oudon 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service License MOTES GERC GORELAE Funeral Balto. Nat'I Pike 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ eri ascular disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed eme attending physician and for use as the burial-trar Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 No Unknown P.O. signed by t d be detacf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🔭 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 **X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0054424 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Fallscraft way Lutherwell MD 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV Registrar

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shou and is m		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Mail	ing Address	(Street a	nd Number or R	ural Route Numb	er, City	or Town, St	ate, Zip C	ode)
ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			L. Bendl	er (M	other)	1200	9 Bela	ir F	Road - K	ingsvil	le,	Maryl	and	21087
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu				build	ing, etc. (Spe	есіту)				City or To	wn, Sta	ate)		
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State Registrar 31. Date filed (Month, Day, Year)

NOV 3 0 2011

10 V

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMAN JUMMES M) 6761 N-Charles ST TONSON MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 0052/AM **Physician** November 23 ,2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NIA Baltimore Cite Balt more traspital 8. Date of Birth (Month, Day, May 17, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days 214-82-7149 Hours 1**01**M 2□ F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it. Medical Examined must be muithed any pincy or other traumatic event, it. Medical Examined must be muithed at once. 1 Yes 2 No saltimore **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 Wes 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status and 2 should be filed within 72 hours after isalth and Mental Hygiene. n 27 is marked other than "natural", or iter 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Yes 2 No Black Specify Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -ducation Moni tall 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Ştate, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balt more Kegina 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Paltimae, 1/2011 LIDI 4 Donation 5 Dother (Specify) Funeral Service L 22. Name and Address of Facility Heights Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. EPS15 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underh in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ Corarmy artery Diker, , CABG Clorman 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 November 23, wil nuc 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sina Hospital of Berltimore AMADED mis 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 3 0

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 38014

		-	For State Of Mary		tificate of D			eg. No.	
	Dhusisis	~/	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	n Day Year	3. Time of Death
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	Examin	er	4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County of Dea	
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Baltimore,	permit. Page 1 Department of Important: If i any injury or o		4 □ Donation 5 N Other (Specify) in state 21. Signate of Funeral Service icenses When the state of Funeral Service icenses with the state of the stat	≠or st	Name and Addres	ss of Facility Omy Board	655 W.	Baltimore	Street
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ţa.	ician: certific ector,	Be	25. Was case referred to medical examiner?		26. Pl	ace of Death (Check			
<u>></u>	Phys r this c ral dir	2	1 ☐ Inpatient 27. Manner of Death 28a. Date of injury	2 ER/Outpatien 28b. Time of	nt 3 🗆 DOA	4 Nursing Ho	me 5 Reside	nce 6 Other (Spe w injury occurred	cify)
ב כ	nding ath. r: Afte ie fune	icat	1 Natural 5 ☐ Pending (Month, Day, Ye 2 ☐ Accident Investigation	ear) injury	work			, ,	
Division of	I or Atte after de Directo I in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (\$	· At home, farm, stre pecify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,
-	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examonly one) 3 Certifying Nurse Practioner: To the best of my	nination and/or invest	tigation, in my opinio	on, death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.
1	To the To the Comp	2	only one) 3 Li Certifying Nurse Practioner: To the bes	t of my knowledge, c	29c. License			9d. Daie signed (Mon	
			> 6 John Wmgdlets	, MO	D2	5443		11/16/	2011
			30 Name and address of person who completed cause of death	n (Item 23a) (Type, P	pole Ro	e, Wis	tmins	te s	b 21157
	Sta Registra		31. Date filed (Month, Day, Year) - 32. Jegistrar's	Signature A.	arke			/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38015 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BENTAHIN AHES 12 10PM November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death North WEST HUSBITAL Randalls town Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Aug 10, Year 925 Director 070-20-0781 86 Nebraska Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Carrol1 1 Yes 2 X No Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4040 Sells Mill Road 21787 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Widowed 4 Divorced 43-46 15. Decedent's Education 16a. Decedent's Usual Occupation un 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) research analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Winfred Benjamin Peggy (Minnie L) Haskell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Benjamin/spouse 4040 Sells Mill Road Taneytown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) ature of Euneral Service RO na La 23 Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disense, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Sepsis disease or condition Medical resulting in death) Due to (or s a consequence of): Examiner seudomembranous Colitis Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury and that initiated events Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical death certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.
To the Funeral Director: After this certificate has E completed filled in by the funeral director, page 2 si autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Box 68760

P.O. I

Records,

Division of Vital

State Registrar

31. Date filed (Month, Day, Year)

Abdallah

old Court Road, Randalls town, HD 21133 5401

Louis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAFrouxi

D65843

Nevember, 16, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Babich Month Georges 11/25/11 6:00am [™] Medical 4a. Facility Name (if not institution, give street and number) **Keswick Multi Care Center** City, Town, or Location of Death Baltimore Examiner 4c. County of Death N/A Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Birting. Country) TL Days Hours 214-30-2719 88 12/24/1922 1**X** M 2 □ F **Director** Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore MD XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 524 N. Charles Street 21201 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 XXIII Never Married 2 - Married Black, White, etc. by Maryland 21215-0036 1 Yes If Yes, Give White 1 ☐ Yes 2XXNo Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Lecturer In Foreign Languages Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Babich Mile Maria Varenika 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor P. Doda /Funeral Director 1501 E. Fort Avenue, Baltimore MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Greek Orthodox Cemetery 12/2/2011 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Maryland Sign here of Formal Service Licensee Victor P. Doda Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore MD 16 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician s the buria Physician/Medical Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy ours after death. eral Director: After this certificate I filled in by the funeral director, pag Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \square Yes Hospital Other: မြ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1. Natural injury 5 Pending 2 🗌 No Investigation M Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Exertifying Nurse Practitioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CO 1 30. Name and address of person who completed cause o 701

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

ИОЛ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Barrett Physician/ Harry 25 2011 7:411 November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Pasadena 6 Dunlap Court Birthplace (State or Foreign Country) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under **Funeral** Months Hours 217 58 1752 1 X M 2 D F Director 61 Maryland 04/11/1950 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 No Anne Arundel Pasadena Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number P pe U.S. Funeral 21122 with 1 23a 6 Dunlap Court permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? Yes 2 No Yes, Give Vi þ 1 Never Married 2 Married If Yes, Give Viet Nam Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Callege (1-4 or 5+) Construction Bricklayer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pearl Chambers ည Harry R. Barrett Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pasadena, Maryland 21122 Bonnie Cochran / sister 6 Dunlap Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Meadowridge Mem. Park 11/29/2011 | Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A.
4001 Ritchie Highway Baltimore, Maryland 21225 Signature of Funeral Service bicensee erome 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Renal Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause (Disease or injury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last physician Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Month Day Year in the past 12 months? Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?/ Yes 2 No death? 1 Yes 2 No After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Other: 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ the funeral 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: work?
1 Yes 2 No 1 Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Director completely filled in by the Suicide 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier nský apahum.D 0057465 11 25/11

DHMH 17 Rev 06-2011

State Registrar 2835 Smith AV

32. Registrar's Signature

5203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapaks, M.D

31. Date filed (Month, Day, Year)

Baltimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 5, per fh, 9922 12-8-11 sm
State of Maryland / Department of Health and Mental Hygiene

			State Registrar			Cer	tificate of l	Death		Reg. N	10.00	1 20018
	Physicia	n/	1. Decedent's Name (First, Middle, I		Describe.				2. Date of D	eath	201	3. Time of Death
244	Medic	al	4a. Facility Name (if not institution, g	Sarah Jane	Bradf	DIO.	4b. City, Town, o	r Location	NOV of Death		2011 Pear Location L	7:59 A M
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death	items ner mi		11. Marital Status	12. Was Decedent Ev Armed Forces?		13. V	/as Decedent of H Yes, specify Cuba	lispanic Or an, Mexica	rigin? (Specify Yes or No n, Puerto Rican, etc.)		14. Race - Ame Black, White	erican Indian,
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland	ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 XN If Yes, Give Year or Dates.	lo	1	☐ Yes 2 X No					hite
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Ma 12 sho	of Health and Mental f item 27 is marked of r other traumatic eve		Robert Bradford		- 1		-		er or Rural Route Number Way, Ches			
Baltimore,	t of Heg If item or othe		20a. Method of Disposition		20b. Place o	f Dispos	sition (Name of eatory or other place		Date	_	Location - City or	
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Bal permit	Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	Alyson K	Taylor				ity Cremation Rd., Baltin			
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Box 68	ed by the attending l detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mmnths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal death		Ectopic pregnand Other (specify)	су			23d. Date of de Month	livery Day Year
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Division of Vital Records, P.O. I tal or Attending Physician: The law requires that the resulter cheap.	this certificate has beeral director, page 2 sho	Completed	Accordance to the second secon						24a. Wa aut per 1 🗆 Yes	opsy formed?	prior to death?	topsy findings available completion of cause of
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of V	eral di	e:	1 ☐ Yes 2 ☑ No 27. Man r of Death	1 Inpatier 28a. Date of injury	nt 2 ER/Ou 28b. 1	Time of	28c. Injur	4 ⊔ N	lursing Home 5 Res			ify) HOSPICE
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Division of Vital To the Hospital or Attending Physician:	within 24 hours after deaut. To the Funeral Director: After this completely filled in by the funeral	Medical	(Check 2 Medical Exa	hysician: To the best of m iminer: On the basis of exa urse Practitioner: To the I	mination and/o	or investi	gation, in my opinie	on, death o	occurred at the time, date	and place	ce, and due to the	cause(s) and manner stated.
To th	7º t comi	-	29b. Signature and title of certifier				29c. Licens				ate signed (Month	n, Day, Year)
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	0		30. Name and address of person wh Barry R. Meisent					polis	s. Marvland	21/	ιO1	
	Stat Registra	_	31. Date filed (Month, Day, Year) NOV 3 0 201	32. Registrar	s Signature	are	J, 23111d	POLCE	, intytalla	2 L "	IOL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Valentina Borisova 4:00 P M November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Althea Woodland Nursing Home Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Ukraine 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Month, Day, Year) 1 □ M 2 💢 Days **Director** Dec. 214-75-1921 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Gaithersburg Montgomery 1XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12101 Bayswater Rd. 20878 Uzbekistan 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. traumatic event, the Medical Examiner Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 💢 No Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify. Completed 3 ▼ Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marchenko Andrey Vera (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12101 Bayswater Rd., Gaithersburg, MD Lyudmila Halpine / Daughter or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State cemetery, crematory or other place) injury Chesapeake Crematory 11/22/2011 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Lipensee 22 Name and Address of Facility Rapp Funeral and Cremation Services any 933 Gist Ave., Silver Spring, 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between TEREOS denotice Immediate Cause (Final Onset and Death Physician/ disease or condition O.a Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Demento 24b. Were autopsy findings available prior to completion of cause of death? performe 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after ueau..

To the Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🔲 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 42

DHMH 17 Rev 7/2009

State Registrar 32. Regiştrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:01 P Carol Ann Block November Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Harford Edgewood 2 McCann Street Ext. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day Ye 1 □ M 2 🔀 F Months Days Hours Min North Carolina Yrs. 1951 Director 216-58-0428 60 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Harford Edgewood 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? Examiner must be Funeral with 23a USA 21040 2 McCann Street Ext. items 2 death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates. Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dorothy Jane Sherrill permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic vonce. J.C. Frisby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 McCann Street Ext., Edgewood, Maryland 21040 John H. Block Jr. / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2011 Hilltop Service Corp: Towson, Maryland Signature of Juneral Service Licensee 22, Name and Address of Facility McComas Funeral Home, P.A. 317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or of shock, or heart failure. List only ligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Myseurdial Pnysician/ cute minutes disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to jor as a consequence of that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death detached the 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe 1 be a Completed by Records, 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown phods 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No re II 24a. Was an has page 2 To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h completed filled in by the funeral director, page Yes 2 N Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ြို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0056607 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 208 PLUMTREE Rd. BEL ADR JOSEPH ANGEZO MD.

State Registrar Year)

NOV 3

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11-08811 Don Bernard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		For State		Certifica	te of l	Death				g. No.		
Physiciar Pedical Examin	1/	. Decedent's Name (First, Middle Don	,Last) Berna	rd				М	ate of Death onth ovember	Day Year		3. Time of Death 2022 hrs
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		Washington Adventist				Takoma Par				Montgon		
Funeral Director				In yrs. last birtho	lay) Yrs.	If Under 1 Year Months Days	If Under Hours	T		29,1976	Foreign	oplace (State or
daryland 28a-f show any 1 at once.	Ī	Usual Residence of Decedent Oa. State 10b. County MD Prince Oe. Street and Number	e George's	c. City, Town or		Adelphi 10f. Zip Code			10	g. Citizen of Wh		10d. Inside City Limits 1 Yes 2 No
the Ma or 28	Director	9410 Riggs Rd	•			2078	83			St. Luc	cia	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho marked other than "natural", or items 23a or 28a-f sho marie event, the Medical Examiner must be notified at once.	Fune	1. Marital Status 1 X Never Married 2 Mai 3 Widowed 4 Divo	12. Was Decedent Everried Armed Forces? 1 Yes 2 Xerced If Yes, Give Year	ver in U.S.	If Yes	Decedent of Hisps, specify Cuban,	Mexican, I			14. Race White Specify:	e, etc.	an Indian, Black, ack
ours a	<u>8</u>	15. Decedent's Education (Speci		, du		s Usual Occupationst of working life.			done	16b. Kind of Bu	siness/In	dustry
5-0036 ted within 72 hours after Hygiene. wher than "antural", the Medical Examiner.	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)		tock	•				Retai]	l Sto	ore
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Fe, and filters of tra	- 1	20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from State			ion (Name of cem er place)	etery,	Dat	te 2011	20c. Location -	City or T	Town, State
Page Page ment of tant:		4 X Donation 5 Other Spe	ecify:	Scienc	e Ca	are		Nov.	28,	Auro	ra	CO
Baltimore, permit. Pages 1 ar Department of Hec Important: If ite injury or other tr	Ţ	21. Signature of Funeral Service I	me me	00382	I Rat	me and Address	aLan	d Cre	matio	n Servi	ces	0910
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Box 68: death certiff the attending of for use as	Physician	1 Yes 2 No 9 Unk	nown 9 Unknown	ne or death 5	Othe	er (Specify)		-				
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To the Hospit within 24 hour To the Funer: completely fill	Medical	one) 2 Medical Exar	miner:On the basis of examinand manner stated.	nation and/or in	vestigatio	on, in my opinion,	death occ	urred at the	time, date a			
FSFS	ž	29b. Signature and title of certifie				29c. License				29d. Date sign		
		total a	Tolle			O.C.N	И.E. ————			November	23, 20	111
,		 Name and address of person Patricia Aronica-Pollal 			ner C	900 W Baltin	nore Str	eet. Balti	more. Mr	21223		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ OCTOBER ์ **1** ั9 **,** 2 0 ๊ ่ โ ่ 1 ACERES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON SAINT JOSEPH MEDICAL CENTER 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 1 M M 2 □ F **Funeral** (Month, Day, Year) OUERTO RICO 585. **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County be filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No BALTIMORE 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral PUERTO RICO 1004 ARMSTEAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?, 1 ☐ Yes 2 🔊 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 □ No Specify: HISPANI & PUERTO RICAN 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) l Hygiene. I other than " College (1-4 or 5+) Elementary/Seconday (0-12) INDUSTRIAL SECURITY GUARD Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o မ ANGELA CACERES ADONFO Department of Health and Men Important: If item 27 is marke any injury or other traumatic Page 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WAY DORIS MENDOZA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State GLEN BURNIE MD. CREMATORY 10/21 ATLANTIE 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig and read Service Licenses BALTO, MD. 21224 2829 H4050 ST. SKARDA FUNERAL HOME or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final ANOXIC ENCEPHALOPATHY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** CARDIAC ARREST Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events CORONARY ARTERY DISEASE attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Yes 2 No 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation after death

Director: / 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours aft

To the Funeral Dir

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of cer D24034

Registrar

NOV 3 0 2011

31. Date filed (Month, Day, Year)

32. Registrar's Signature

LOW, M. D.

ripleted cause of death (Item 23a) (Type, Print)

7601 OSLER DRIVE TOWSON, MD 21204

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	,				ate of deli	very Day Ye	ar
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al or Atte s after dea il Director ed in by th	l Certificate:	3 Suicide 6 Could no 4 Homicide determine	t be 290 Place of Inju		rm, stree	et, factory, office			_ocation (Stre City or Town,		ber or Rur	al Route Numbe	r,
he Hospit in 24 hour he Funera pleted fille	Medical	(Check 2 L Medical Exa	hysician: To the best of aminer: On the basis of en lurse Practioner: To the	xamination and/or	r investig	gation, in my opinion	n, death occurred	d at the ti	ime, date and	place, and di	ue to the c	ause(s) and manr	ner stated.
Tot With Co∃	_	29b. Signature and title of certifier	Rem	- M	1	29c. License	-	243		d. Date signe			
		30. Name and address of person wh	o completed cause of de	eath (tem 23a) (1	-		Mac 27.	11/1	7 4011	11711			
Stat Registra		3 Day (Month Day, Year)	Server 32. Registra	ys Signature	1	- J J 11/1	, () /	-411	- 10 11	1111			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:55 A^M Eva Carr 11/26/2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Examiner Carrol1 Lorien Nursing Home Taneytown If Under Birthplace (State or Foreign Country) If Under 24 Hrs. . Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min. Director 213-28-2381 1 M 2 X 95 4/3/1916 WV Usual Residence of Deced 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 X No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 225 Frock Dr. 21157 USA be filed within 72 hours after death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces? Black White etc ò by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 'natural", 3 XWidowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Her Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1. Department of Health and Mental Important: If item 27 is many injury or other. 0 DeSota Totten O'Mega Hanna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gallway Dr., Hanover, PA 17331 Betty Jo Dittmar/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 11/30/2011 Winfield, MD 21. Signature of Funeral Service Licenses ²Burrier Que en Funeral Home & Crematory, Total O Kel 1212 W. Old Liberty Rd., Winfield, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (a a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be each tours after death.
 Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending **X**Natural 1 Yes 2 🗌 No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and title of certifie 29c. License number

Registrar

State

31. Date filed (Month,

0 3 NOV

32. Registrar's Signature

cole Rd.

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 38025 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month ONNE FLLEN NOVEMBE 2011 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Catonsville Commons Nursing Hom**e** Catonsville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number Funeral (Month, Day, Year) 09 25 Months 1 🗆 M 2 屎 F Min. 218-07-2855 Director MD Usual Residence of Decedent ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Tes 2 No MD Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 801 Winters Lane Apt 334 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " New Psalmist life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baptist Church 12th grade 4yrs Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or and in Daniel Young Beatrice Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Edward Young-Brother</u> 810 Mt. Holly Street, Baltimore, Md 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 11/30/2011 Garrison Forest Vet Owings Mills, Md 21. Signature of Fun ervice Lice 22. Name and Address of Facility
March F/H West
4300 Wabash Av Ave Baltimore 23a. Part 1. Epier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ HEALTHCARE AND disease or condition Medical resulting in death) PNEUMONIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): YEAR. and I-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MODERATE PULMONARY HYPERTENSION 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? BLEEDING ARTERIOVENOUS MALFORMATIONS OF 24a. Was an autopsy has THE BOWEL performed? Yes 2 No VALVULAR HEART DISEASE certificate 2 🗌 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1**'🔀** Natural 5 Pending work? 2 \square No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a
To the Funeral C Medical 1 K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 5 29d. Date signed (Month, Day, Year) 00018362 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455, Wilkens Md21229 Komalk Dang

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #I Per PHY G921 11/30/2011 JH
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 38026 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Laurence C. Covey Month Novembia Day 2011 LAWRENCE 5:57 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Joseph Hospital Towson Baltimore 8. Date of Birth

Amonth, Day, Year)

A Jeust 5, 1947 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Hours Min. 1 M 2 D F Director Yrs. 212-50-5402 64 MD Usual Residence of Decedent 28a-f shov 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Phoenix 1 ☐ Yes 2 🔀 No 10e, Street and Number 5 10f, Zip Code 10g. Citizen of What Country? be 1 Funeral 23a must 13 Greentree Dr. 21131 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14 Race - American Indian ir than "natural", or iter the Medical Examiner Black, White, etc. ģ 1 Never Married 2 X Married 1 Yes If Yes, Give 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction n/a Operating Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be f. Department of Health and Mental Important; If item 27 is marked any injury or other traumatic ev မ Victor Covey Elizabeth Dantoni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Covey/wife 13 Greentree Dr., Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 11/29/11 Glen Burnie, MD 21. Signature of Uneral George Licensee

Michael J. Flagle 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 San 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. lediate Cause (Final and Cause) and the control of the control of the cause of condition and the cause of condition and the cause of cause (Final cause) and the cause of cause (Final cause) and the cause of cause (Final cause) and the cause of cause of cause (Final cause) and the cause of cause (Final cause) are caused the cause of cause (Final cause) and the cause of cause (Final cause) are caused the cause (Final cause) and the cause (Final cause) are caused the cause (Final cause) and the cause (Final cause) are caused the cause (Final cause) are caused the cause (Final cause) and the cause (Final cause) are caused the cause (Final cause) are caused the cause (Final cause) and the cause (Final cause) are caused the cause (Final cause) are caused the caus Approximate Interval Retween Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 → Yes 2 → No 3 → Probably 4 → Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsi RITEUMATOID ACTIVEITIS 1 Yes 2 No MA 1 ☐ Yes 2 🗷 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: ဥ 1 Yes 2 No Other: 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending iniury work? 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number November 28, 2011 MO DO062966 Alche 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9T1V YETER S GREENE TOWSON MA 1447 YORK RO 21093 80172 100 31. Date filed (Month) State

Registrar

Maryland 21215-0036

3altimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 27, 201^{Yea} 5:06 PM M Susie Caulk Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia 5612 Roundtree Lane 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Aug 15, Months Hours 156-36-8439 Director 1930 1 🗌 M 2 🛣 F Korea 81 Yrs r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21045 USA 5612 Roundtree Lane filed within 72 hours after death val Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify asian 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker Be unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Othelia Ross/Dept on Aging 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1 Burial 2 Cremation 3 Removal from State 5 N Other (Specify) in state रियार हार्ज Adda र असिङ् । Board 655 W. Baltimore Street MD21201 Baltimore, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Car anoma Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) death certificate be executed Cause (Disease or injury detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year P.O. or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? S S Records, 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSule/110 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at hours after death. neral Director: After 1 Natural 5 Pending work 1 Yes 2 \square No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check 29c. License number
D 30641 29b. Signature and title of certifier No Wember 14 2011 Back River Neek Road Ballimy May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sabapathi

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

11-08302 John Crawford

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State Certificat	e of Death	Reg. No.	
Physician			2. Date of Death	3. Time of Death
Madical Examine	John Crawford		Month Day Year November 5, 2011	1745 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	eath
	University Hospital	Baltimore City		
Funeral	5. Social Security Number 1111 & 6. Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9.	
Director	1¼m 2□F 43	Months Days Hours Min. Yrs.	Feb 13, 1968	reign Country)Maryland
	Usual Residence of Decedent			
Au A	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
*	MD Balt	imore		1 Yes 2 No
Maryland 28a-f show d at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	country?
the Maryland a or 28a-f sh tiffed at one Director	2 E. Preston Street	21202	USA	,
with the 18 23a of 18 23a				
th wi	11. Marital Status 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Spending Yes, specify Cuban, Mexican, Puerto I		nerican Indian, Black, c.
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s afte	or Dates:	1 Yes 2 No specify:	Specify: W	
hour Exar	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	cedent's Usual Occupation (Give kind of w ing most of working life. DO NOT use retir		ss/iridustry
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with with Mer 1	11 0	cook	(First, Middle, Maiden Surname)	ildustry
THE BEST OF				
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica			Crawford	
Should and Me affices		Mailing Address (Street and Number or R		
Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Reath and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumante event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		46 Wilkens Avenue B	Date 20c. Location - City	223
of He		or other place)	Zoc. Location - City	or rown, state
Page nent o	4 Donation 5 X Other Specify: in/state			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumante event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		23 Nane and Address of Fry lity Boar	d 655 W. Baltimo:	re Street
o sali	Jun Mill	Baltimore, MD 212	01	
Physician	23a. Pan I. Enter the disease, or complications that caused the death. Do not e faiture vist only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest, shock, or heart	Approximate Interval Between Onset and
√Medical £xaminer	Immediate Cause (Final disease a. Acute Alcohol Into	oxication		Death
∠xammer.	or condition resulting in death) Due to (or as a consequence of):			
	Sequentially list conditions, b.			
red Insit	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
ua ua	(Disease or injury that initiated Avents resulting in death) Last Due to (or as a consequence of):			-
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box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Exi	■ AMENDED 23a,27,28a-f	,per me,g922 12-1-1	1 sm	
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P.C. res that signed be detected by			1 Yes 2 No 3 P	robably 4 🗹 Unknown
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Physical direction of T	1 ✓ Yes 2 No		Home 5 Residence 6 Ot	her:
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	27. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural 5 Pageting		28d. Describe how injury occurred Inknown	
sior trend death cror: y the	Pending fd 11-5-11 fd 5	20 pm		
Division o spital or Attending tours after death. neral Director: After filled in by the fune Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm	, street, factory, office building, etc.	28f. Location (Street and Number or or Town, State) 2 East	
Divis Hospital or A 24 hours after Funceral Directely filled in b	4 Homicide determined (Specify) Residence		Baltimore, Md.	Trobbon be.
9 - 3 9	(Check only 1 Certifying Physician: To the best of my knowledge, death			
Di To the Hospital within 24 hours a To the Funeral 1 completely filled	one) 2 Medical Examiner: On the basis of examination and/or inversand manner stated.			
ž Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (#	Month, Day, Year)
	Yeinel Touthall, MI)	O.C.M.E.	November 6, 2	2011
	30. Name and address of person who completed cause of death (Item 23a)			
	Pamela E. Southall, MD Assistant Medical Examiner	900 W. Baltimore Street, Baltim	nore, MD 21223	
State		1.11		
Registra	NOV 0 0 2011 /2 8. 1	facel		

CARTE	2	MFDFORD Please amend #19	Type or Print in I a PerFH G922 1. State of Marylan	Black,Indelib	le Ink. Ensure JH	All Copie	s Are Legibl	e.
		For State Registrar	State of Marylan		nt of Health and te of Death	Mental Hy	giene Reg. No. 201	1 38029
Physic		Decedent's Name (First, Middle, Last	Medford F. Cart	er, Jr.		2. Date of De Month	Day Yea	3. Time of Death 22:50 p M
Exam	dical iner	4a. Facility Name (if not institution, give			, Town, or Location of Dea	th	4c. County of D	eath
Funer Directo	_	Union Memorial Hosp 5. Social Security Number 6. S 219-07-9254 1			er 1 Year If Under 24 Hr		th 9.	Birthplace (State or Foreign Country)
yland f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location		Tragase 2	1,1,22	10d. Inside City Limits 1XX Yes 2 □ No
the Mar or 28a-	Director	MD N/A 10e. Street and Number		Baltimore 10f. Zi	p Code		10g. Citizen of What	Country?
th with ms 23a	Funeral	4401 Hickory Avenue	12. Was Decedent Ever in U.S	3 13 Was Dece	21211 dent of Hispanic Origin? (\$	Specify Yes or No-	U.S.A	merican Indian,
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at	ed by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates 44-46	If Yes, spe	cify Cuban, Mexican, Puel 2 XXNo Specify:			/hite, etc.
21215-0036 within 72 hours after gigne. er than "natural", o t, the Medical Exam.	Completed by	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decedent's Usu (Give kind of we life. DO NOT us	ork done during most of we	orking	16b. Kind of Busine	ess/Industry Condominiums
212 d within tygiene. ther tha	Be Cor	Elementary/Secondary (0-12) unknown	College (1-4 or 5+)	Security		(F., t. A. E. J. II.)		Ondommuns
rland d be filed Aental H irked of	PB B	17. Father's Name (First, Middle, Last) Medford F. Carter, S	r .			t Maybell	Maiden Surname) Jackson	
Maryland 2 should be filed tth and Mental Hy 27 is marked oth traumatic event	ŀ	19A Titreet's Mary Telation to 1 Alice M. Carter (Wil	tvan (wife)	19b. Mailing Addres	ss (Street and Number or F ry Avenue Bal	ural Route Number to, MD 21		, Zip Code)
Ore, je 1 and t of Hea If item or other		20a. Method of Disposition 1XX Burial 2	1 D C4-4- G	Place of Disposition (Na emetery, crematory or	ame of other place)	Date	20c. Location - City	
Baltimore, permit. Page 1 and Department of Hea mportant: If item any injury or othe	Ge	4 Donation 5 Other (Speci 21. Signature of Fineral Service Licens	(y) Mary	- 1	s' Cemetery 12 Md Address Seitz' Fur		Garrison Fo	orest, rid
a Bee	o I	23a. Part 1. Enter the disease, or com	phoalions that caused the death	3631 FA	11s Road Balto	o, MD 2121	1	Approximate
Physicia Medic	_	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a. Due to (or as a cons ou	M 515				Interval Between Onset and Death
Examin	er	Sequentially list conditions, if any, leading to immediate	b stage	IV Long	Caner			2 weeks
scuted and -transit	xamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a a onseque.					
760 icate be exec	ΙШ	resulting in death) Last	Due to (or as a consequent	uence of):				
ox 68760 eath certificate be attending physical drouse as the ballons.	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	incy			23d. Date o	f delivery
Box e death of the attentiched for u	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		specify)		Month	Day Year
, P.O. Bc es that the dea signed by the a	2	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	g cause given in Part 1.			e to the cause of death?
Records, The law requires cate has been sig	Completed					24a. Was	an 24b. Were	Probably 4 Unknown e autopsy findings available to completion of cause of
Recc The law	Comp						ormed? deat	
of Vital ng Physician: ter this certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ER/Outpatient 3 🗆 I	26. Place of Death (Chapter) Other: 4 \(\sum \) Nursing		idence 6 🗆 Other (S	specify)
n of ding Phy. After thi		27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurred	
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be exemple 4 hours after death. The law requires that the death. The functal Director. After this certificate has been signed by the attending physician a mpletely filled in by the funeral director, page 2 should be detached for use as the burial-	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not t 4 Homicide determined	De 280 Place of Injuny - At he	ome, farm, street, facto			(Street and Number of wn, State)	Rural Route Number,
Divi To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check 2 Medical Exam	rsician: To the best of my know inner: On the basis of examination	n and/or investigation, is	n my opinion, death occurre	d at the time, date	and place, and due to	the cause(s) and manner stated.
To the within 2 To the comple	ž	29b. Signature and title of certifier	se Practitioner: To the best of r		ocurred at the time, date and Oc. License number	d place, and due to	29d. Date signed (M	
	-	> Hassan N	asser ND	220\ (Time Drint)	053617	7	11/26	11
6x1 v		30. Name and address of person who	Onion M	12 monal	Hospital	2018	Envivors	ty Parkway
S Regis	tate strar	31. Date filed (Month, Day, Year) NOV 3 0 201	2. Registrar's Signa	parke				

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 3 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MITUL DAVE 9056 Chev Ab)

32 Registrar's Signature

Physician

/Medical

Examiner

Director

Be Completed by Funeral

ဂ

Funeral Director

State Registrar			Certifica	ite of De	ath	Reg	3. No. 20		38030
Decedent's Name (First, Middle,	Last)					2. Date of Death Month	Day		3. Time of Death
CHARLES JAME	S CAMPBE	ELL				November			9:58 P M
Facility Name (If not institution,			4b. City	y, Town, or Loc	cation of Deeth	1	4c. County		
Patuxent River				aurel				nce Geo	
Social Security Number		7. Age (In yrs. last bir	Months		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear)	Country)	
216-24-9086	XXM 2□F	82	Yrs.			Feb 28,	1929	Maryl	
ual Residence of Decedent a. State 10b. County		10c. City, Tow	n or Location					104	Inside City Limits
AD Howard		Laure							1 □Yes 2√1No
				in Code		1.0	I. Citizon - '	What Country?	
Street and Number	003			Zip Code					-
23 N. Laurel R		tont Free Land		0723	nic Orient Control		U.S.A.		Indian
Marital Status	Armed Fore	dent Ever in U.S.	If Yes, sp	pecify Cuban, N	anic Origin? (Sp Mexican, Puerto	pecify Yes or No- o Rican, etc.)		ice - American I ack, White, etc.	
1 ☐ Never Married 2 ☐ Marrie 3	If Yes, Give	е	1 □Yes	2₹No S	Specify:		Specif	ify: Whit	.e
	Year or Da	ites:	. Decedent's Us	ual Occupation	า	10	-	Business/Indust	
15. Decedent's (Specify only highest	grade completed)		Decedent's Us. Give kind of w. life. DO NOT	vork done durii	n ng most of work	king		JoannuuS	
Rementary/Secondary (0-12)	College (1-	-4or 5+)	Mechan:				Auton	motive	
Father's Name (First, Middle, La	1 7 <i>st</i>)				. Mother's Nam	ne (First, Middle, Ma			
narles P. Campb					Haytte	German			
a. Informant's Name/Relationshi		101), Mailing Add			ral Route Number, (City or Town	ı, State. Zin Co	nde)
a. Informant's Name/Relationshi .lbert T. Duck	p (Type. Print) / nephe	1 _	524 N.		_	rai Houte Number, t Laurel, M		n, State, Zip Co 723	,
. Method of Disposition	, πεδιιε	20b. Place o	of Disposition (N	lame of				- City or Town,	, State
Method of Disposition Mathematical 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of the Con		State cemete	wridge	r other place)	}			y, Mary	
Signature of Funeral Service L	ensee		22. Name Dona I	and Address o	f Facility ineral	Home, P.A			
1951	+n	_/ моотто			Avenue		Mary	land 2	20707
Ba. Part 1. Enter tim disease, or c shock, or heart failure. List o	omplications that can	sused the death. Do	not enter the mo	ode of dying, s	such as cardiac	or respiratory arres	st,	Int	pproximate terval Between
mediate Cause (Final	, Jause on ea	SOPHA	(ICA)	1/1	ANCI	EK		Ö	nset and Death
sease or condition sulting in death)	a. Due to	or as a consequence	of):	- (
		531.30qu61108	,						
quentially list conditions,	bbue to (c	or as a consequence	of):						
my, reading to immediate									
use (Disease or injury	^	N. 00 0 000000	of):				<u>,</u>		
use (Disease or injury it initiated events	CDue to (r	or as a consequence							
use (Disease or injury t initiated events	CDue to (c	л as a consequence							
quentially list conditions, any, leading to immediate use. Enter Underlying use (Disease or injury at initiated events sulting in death) Last	c	л as a consequence							
use (Disease or Injury at initiated events sulting in death) Last	d	come of pregnancy					23d D	Date of delivery	
use (Disease or Injury to Initiate over the Initiated Section 1997) and the Initiate of Initia	d	come of pregnancy		c pregnancy			6.60	Date of delivery	
use (Disease or injury it initiated events sulting in death) Last FEMALE: b. Was decedent pregnant	d	come of pregnancy birth 2 ☐ Fetal death	n 3□ Ectopic 5□ Other (6.60		
use (Disease or Injury tinitiated events ulting in death) Last FEMALE: b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d	come of pregnancy birth 2 Fetal death ant at time of death own	5 Other ((specify)	in Part I.	23e. Did toba	М	Month Da	
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ise (Disease or injury initiated events ulting in death) Last EEMALE: . Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	come of pregnancy birth 2 Fetal death ant at time of death own	5 Other ((specify)	n Part I.	1 ☐ Yes 24a. Was en autopsy performe	Macco use cons 2 □ No 24b.	ntribute to the c 3 ☐ Probabl	cause of death? cly 4 Unknowr y findings available letion of cause of
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Juse (Disease or Injury initiated events ulting in death) Last FEMALE: . Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown II. Other significant condition Was case referred to medical	23c. If yes, outd 1	come of pregnancy pirth 2□ Fetal death at time of death own	5 Other (g cause given in	6. Place of Dea	1 Yes 24a. Was en autopsy performe 1 Yes 2	Macco use cons 2 No 24b.	ntribute to the c 3 □ Probabl D. Were autopsy prior to complete death? 1 □ Yes 2 €	cause of death? cly 4 Unknowr y findings available letion of cause of
Jee (Disease or Injury Linitiated events ulting in death) Last FEMALE: D. Was decedent pregnant in the past 12 months? 1	d	come of pregnancy irth 2 Fetal death ant at time of death own eath but not resulting i	5 □ Other (g cause given in	6. Place of Dea	1 Yes 24a. Was en autopsy perform 1 Yes 2	M acco use con c 2 No 24b.	Anonth Danntribute to the contribute to the contribute to the complete the contribute the contribute to the con	cause of death? cly 4 Unknowr y findings available letion of cause of
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EMALE: . Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown II. Other significant condition Was case referred to medical examiner? 1 Yes 2 No Manner of Death	d	come of pregnancy irth 2 Fetal death ant at time of death own eath but not resulting i	5 ☐ Other (in the underlying utpatient 3 ☐ I Time of Injury M	g cause given in 26 DOA Other: 28c. Injury at Work? 1 □ Yes	6. Place of Dea 4 Winsing H	1 Yes 24a. Was en autopsy perform 1 Yes 2 th (Check only one)	M acco use con a 2 No 24b. acco use con b 1 Ot v injury occu	Anonth Da Intribute to the complete autopsy prior to complete autopsy prior to complete ath? 1 Yes 2 further (Specify)	cause of death? cause of death? dunknowr y findings available letion of cause of

To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical

State

29d. Date signed (Month, Day,

2/042

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. Year Security Number 7. Age (In yrs **Funeral** 1 M 2 □ F Months Days 423-18-441 Usual Residence of Deceden Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 Pres 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced "natural", permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medicall once. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 755 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition gemetery, crematory Town, State Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. P. H. En France Isease, or complications that cause on short, and failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Qause (Final disease or condition resulting in death) **Physician** METABOLIC ENCEPHALLIPATITY /Medical Due to (or as a consequence of): Examiner to vance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. | 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has breector, page 2 s 2 L No 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Manth, Day, Year) 29b. Signature and title of certifier mus

10x,

State Registrar

NOV 3 0 201

31. Date filed (Month, Day, Year)

UNEGBU, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 G

		For State	State of M		d / De _l	partment of H partificate of D	ealth and Me	ntal Hygie	ene		38032
Physicia		1. Decedent's Name (First, Middle, L		0.11		HAW,	2	Date of Death Month	Day	Year	3. Time of Death
Medic Examin		4a. Facility Name (if not institution, give street and number) Mandrin Care Center				4b. City, Town, or Location of Death Harwood			4c. County of Death Anne Arunde1		
Funeral Director	ctor			ge (In yrs. Ia 48	st birthday Yrs.) If Under 1 Year Months Days		Date of Birth	963	9. Birthpla Countr	ace (State or Foreign Michigan
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or						od. Inside City Limits 1 ☐ Yes 2 🋣 No
	Funeral Director	Maryland Anne Arundel 10e. Street and Number 2004 Kintore Circle, Apt. 101							g. Citizen of W		ry?
	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		13	13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ▼ No Specify:						
	Completed	(Specify only highest grade completed) (Gir				in kind of work done during most of working			6b. Kind of Business Industry epartment of Justice		
	To Be	17. Father's Name (First, Middle, Las Dudley M. Cutshav	18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Goupil								
		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana McKittrick/Sister 2140 Hardwood Dr., Davison, MI 48423								nde)	
Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition 1 □ Burial 2 汉 Cremation 3 4 □ Donation 5 □ Other (Spe	Removal from State	, C6	emetery, ci	position (Name of rematory or other place rematory II			oc. Location - altimo	-	_{vn, State} aryland
permit. Departi Import any inji		21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death. Whithin 24 Hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit a P U	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):									
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):									
	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	12 months? 4 Pregnant at time of death 5 Other (specify) Month								ry Day Year
requires that the de- been signed by the s should be detached	Certificate: To Be Completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							Did tobacco use contribute to the cause of death?		
sician: The law req s certificate has bee lirector, page 2 shoi									ed? d	Vere autops prior to com leath? Yes 2	sy findings available apletion of cause of
sician s certif lirector		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	iant 2 🗆	ED/Outpot	26. Pla	ce of Death (Check or		- 0 D Out-		CM ANDRIN
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28b. Time injury	e of 28c. Injury at 28d. Describe how injury occurred				NospicE			
ital or Atte urs after de ral Directo lled in by tl		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)				City or Tow					
the Hosp thin 24 hou the Funer mpleted fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
o o o		29b. Signature and title of certifier	no by	7_		29c. License	2756		d. Date signed	120	1/
5			RROTT, M	10 4	45 1	Defense	Huy. A.	VNAPI	113 M	41) 2	1401
Stat		31. Date filed (Month, Day, Year)	32. Registr	ar's Signati	Lau	las	•	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1215 PM November 23,2011 Walter Casimir Czaikowski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Memorial Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 218-22-9769 Director 1**火** M 2 □ F 81 May 4,1930 Marvland Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location must be notified at **Funeral Director** Md. Baltimore City 1 X Yes 2 No 10f. Zip Code 10e, Street and Number o 10g. Citizen of What Country? items 23a 21224 36 South Potomac Street U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 Completed by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: "natural", 3 Widowed 4 Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical soce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Printer Envelope Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jozef Czajkowski Serafina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 36 South Potomac Street Baltimore, Md.21224 Theresa Czajkowski 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 🗌 Burial 2 🔀 Cremation 3 🗖 Removal from State Bayview Crematory | 29, 2011 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (of as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequal that initiated events Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes within 24 hours after ueau...

To the Funeral Director: Af 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best ny knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) D0053539

State Registrar 201 Bast University Parkuay/Baltimore

Name and address of person who completed cause of death (Item 23a) (Type, Print)

-inton

31. Date filed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State of Maryland / Dep State Registrar	artment of Health and it rtificate of Death	лена пу	Reg. No. 2011 38034					
	Physicia		1. Decedent's Name (First, Middle, Last) AMY J. DABBS		2. Date of Dea Month	ath 3. Time of Death Day Year					
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Nov.	21. 2011 4:53 A M					
			Holy Cross Hospital	Silver Spring		Montgomery					
	Funeral Director		5. Social Security Number 214–04–4959 6. Sex 7. Age (In yrs. last birthday) 37 Yrs. 37 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Day June 25,	th 9. Birthplace (State or Foreign y, Year) Country) 1974 Maryland					
	and show lat	è	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits								
	Maryl 28a-f otifiec	Director	Maryland Montgomery Silver Spri	ng		1 ☐ Yes 2 🎛 No					
	th the 3a or the n		10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?					
	ath wi	Funeral	3902 Minden Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20906 Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	U.S.A. 14. Race - American Indian,					
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Light Never Married 2 Light Married 1 Light Yes 2 Light No	Was Decedent of Hispanic Origin? (Spa If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	Rican, etc.)	Black, White, etc.					
0	hours a	Completed	3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Dece	dent's Usual Occupation		16b. Kind of Business Industry					
215	nin 72 l ne. han "r s Med	dwo	Elementary/Seconday (0-12) College (1-4 or 5+) life. E	kind of work done during most of work OO NOT use retired)	ing	, os ruma or sacrification					
2	filed with al Hygier d other t	Be C	N/A N/A 17. Father's Name (First, Middle, Last)	Dependent 19 Methov's Nom	o (First Middle	Dependent Maiden Surname)					
<u>lan</u>	l be file fental rked c ric eve	욘		abbs Vickie	_	Conner					
Maryland 21215-0036	2 should be and Me 27 is mark		/m / \ /m /	ng Address (Street and Number or Rura							
	and 2 Health tem 2;	1	John Dabbs (Father) 276 20a. Method of Disposition 20b. Place of Disp	10th Street Pasadena,	MaryLand Date	20c. Location - City or Town, State					
E E	Page nent c int: If		1 Burial 2 XCremation 3 Removal from State cemetery, cre	matory or other place)		Glen Burnie, Maryland					
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other		21. Signature of Funeral Service Licensee M00175 2	2. Name and Address of Facility McC	ully-Poly	miak Funeral Home, P.A.					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter	that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate							
A.	h, sician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	URE DISORDI	ÉR	Interval Between Onset and Death					
	Medical Examiner	iner	resulting in death) Due to (or as a consequence of):								
			Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
38	and transit	Examiner	Cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):								
)	certificate be executed nding physician and use as the burial-transit	Aedical E	resulting in death) Last Due to (or as a consequence of):								
8760		Medi	IF FEMALE:								
Box 68	death cer he attendii ed for use	cian/	23b. Was decedent pregnant in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year					
Ö.	requires that the death certific been signed by the attending should be detached for use as	by Physician/N	1 Yes 2 No 4 Pregnant at time of death 5 to 9 Unknown								
, P.O.	s that igned b	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?								
rds	require	eted	MENTAL RETAR DATION 1 Yes 2 No 3 Probably 4 Unknow 24a. Was an 24b. Were autopsy findings available								
ecc	ne law e has l	Completed			autor perfo	utopsy prior to completion of cause of death?					
<u>e</u>	sician: The la certificate ha irector, page 2		25. Was case referred to medical examiner?								
<u>=</u>	Physician: Tribis certificated director, presented of the control	욘	1 Ses 2 No Prospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
0 00	ading Phath. : After the funeral	cate	1 Matural 5 Pending (Month, Day, Year) 2 Accident Investigation	f 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe h	be how injury occurred					
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detach.	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (S City or Tow	(Street and Number or Rural Route Number, own, State)					
۵	spital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, as	nd due to the ca	use(s) and manner as stated					
	he Hos in 24 h he Fun pleted	Medical	(Check only one) Check only one Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	t the time, date a	and place, and due to the cause(s) and manner stated.					
	Vith with Con		29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)					
	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
_	1		SURESHKUMAR MUTTATH, STILL S PAR	IVIS AVENUE SUI	TE 200	RIVERDALE, NO 20137					
	Stat Registra	~	31. Date filed (Month, Day, Year) NOV 3 0 2011 2. Registrar's Signature	Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38035 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6.55 M Month 24 2 201 Medical 4c. County of Death
Baltmore Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Kesville sardens If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 1 E Months Hours Min. Country) MID Director 106 Yrs Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City_Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 🗆 No Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 30 Widowed 4 Divorced Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Harry Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Place 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) injury or Baltima 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sure Funeral Service Licen 2010 MID 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician disease or condition resulting in death) Month Medical Due to (or as a consequence of): Examiner Sequentially list conditions, tany, learning to minimize cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death the detached 9 Unknown a 🗌 Unknown completed filled in by the funeral director, page 2 should be detact Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 2 🗖 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Vital 25. Was case referred to nedical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: ပ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man of Death ot 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1
Yes Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending Division 2 🗌 No 2 Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signat re and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nth, Day, Registrar's Signaty State 3 0 2011 Registrar

DURSE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 201 9:15 P November Kathleen Marie Deemer Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Linthicum Tate Chesapeake Hospice House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 70 **Director** 220-38-1897 1 M 2X F Maryland August 31, 1941 Usual Residence of Decede 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 R No Severn Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral United States 7959 Telegraph Road, 21144 "natural", or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 1 Never Married 2 🔀 Married þ Maryland 21215-0036 1 Yes 2 No If Yes Give White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Prince George's permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) County Public Schools Cafeteria Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည George Conway Lucy Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7959 Telegraph Road, 1A, Severn, Maryland 21144 Lester L. Deemer/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Maryland National Memorial Park November 28, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 2011 ^{22. Name and Address of Facility} Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Signature of Funeral Prvice Licensee M01386 23a. Part 1. Enter the shock, or heart cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death failure. List only o Immediate Cause (Final Physician/ Ø disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 0 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to jui as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 38 IF FEMALE for use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown Records, 1 Yes 2 🗌 No 3 Probably director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 NG ၉ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 5 Pending Watural 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 29b. Signature and title of certiffe 29c. Lice 29d. Date signed (Month, Dav. Year) cause of death (Item 23a) (Type, Print

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38037 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Richard George Dorohovich 2011 10:40 p Medical November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Hours Min **Director** 136-42-7243 1 🔀 M 2 🗆 F 62 Usual Residence of Decedent 1949 1, New Jersey 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 926 Hamburg Drive 21009 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black. White, etc. 1 Never Married 2 Married ð 1 X Yes If Yes, Give 2 No Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene, marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Letter Carrier U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen (nmn) Dorohovich Sophie (nmn) Andrusky and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Audrey C. Dorohovich / Wife 926 Hamburg Drive, Abingdon, MD 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specif)Entombment Air Memorial Gdn. 11-28-11 Bel Air, Maryland of Funeral Service Licer Signat McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1 Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate bases. Enter underlying Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has h page 2 autopsy this certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Certificate: To Other: Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending injury 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and itle of ce 29d. Date signed (Month, Day, Year) D0071287 11-52-11 Name and address of person who completed cause of death (Item 23a) (Type, Print) Stables, 6791 N. Charles St Suite 4105, Baltimere, MD 21204

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Richard Eugene Donahoo Sr. November 27 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death tizens Harford Grace Home rsina Haivre Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Maryland **Funeral** If Under 1 Year 1**X** M 2 □ F Months Days Hours Min. Director 215-30-6842 78 Dec Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant, If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Joppa 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 333 Sweetbrier Court 21085 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 ₩ Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Steel Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Theodore (unk) Donahoo traumatic Catherine (unk) Powers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other t <u>Darlene Somers</u> / Step-Da**x**ghter 622 Boxelder Drive, Edgewood, Maryland 21040 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important; If ite any injury or oth 20c. Location - City or Town, State 1 X Burial 2 Crer 4 🗆 Da Dulaney Valley Cem. ion 5 🗆 6 12/2/2011 Timonium, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. Þ 1317 Cokesbury Road, Abingdon, Maryland 21009 t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner burial-transit and resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes ≥ ☐ 9 ☐ Unknown Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Mnknown 24b. Were autopsy findings available 24a, Was an has autopsy performed prior to completion death? 2 No Yes 1 Yes Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Donahoo Acciden

Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed M. Min 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MY). 2107 31. Date filed (Md State NOV Registrar

ORIGINAL

Richard

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38039 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 27, **Physician** PAUL C. ERGLER, SR. 2011 0913 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8820 WALTHER BLVD. PARKVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1/30/1919 5. Social Security Number Sex 11 M 2□ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. PENNSYLVANIA Director 201-07-1681 92 Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evandation and be notified at Director MD BALTIMORE PARKVILLE 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 WALTHER BLVD. APT. 2408 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **∐X**o Baltimore, Maryland 21215-0036 Completed by 1 ☐Yes 2X No Specify: Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) ENGINEER GLEN L. MARTIN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ADOLPH ERGLER MAUD PAGE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENNIFER ROBINSON/DAUGHTER 2131 CORBETT RD. MONKTON, MD 21111 20b. Place of Disposition (Name of ST - JOHN EVANGELICAL 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/1/2011 PHOENIX, MD LUTHERAN CH. CEM.
22. Name and Address of Facility 21. Signature of Funeral Service Li ensee MO1/139 THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVD Physician Month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, € Due to (or as a consequence of): physician Physician/Medical yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐Yes 2 ☐ No 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed? Yes 2 No certificate 1 □Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \sum Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 A Natural 5 | Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. (Check only one) within 2 To the I

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jeff

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Landuman

8 FOO

32. Registrar's Signature

Walth

29c. License number

DJ3111

ar kulle

mo

29d. Date signed (Month, Day, Year) November 28th 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 38040 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Eichelman Physician/ Month -rances November 2011 2:55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Encore of Turf Valley Ellicott City Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Hours Min Director 213-28-5440 1 □ M 2 😾 F 80 Yrs Jan. 18, 1931 Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore 1 🗆 Yes 2 🔀 No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1601 Park Grove Avenue 21228 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give X
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done duning most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Louis A. Schneider Frances Catherine Brannan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Woytowitz / Daughter β024 Patuxent Overlook Ct., <u>Ellicott City, MD 21042</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem'1 Gdns_11/28/2011 Marriottsville, MD 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ Non Small disease or condition 42ars Medical resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a nonsequence of: Exami resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🔀 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted

Examiner burial-transi attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760 signed by the atter page 2 s certificate has After this funeral the Hospital or Attending

or 28a-f show

items 23a or ner must be r

permit. Page 1 and 2 should be filed within 72 hours after death bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m

Baltimore, Maryland 21215-0036

notified at

မ Certificate: e Funeral Director: Affeletely filled in by the fu Medical within 2
To the comple

Hospital: 2 X No. Other: 1 Yes 1 Inpatient 2 Inpatient 3 Inpa 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury ☐ Accident☐ Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) caton Ave, Mailbox 235, Baltimore, MD 21229 Yarlagadda , MD 900 31. Date filed (Month, Day, Year)

29c. License number 59027

11-25-2011

Registrar

29b. Signature and title of certifier

Lavan

32. Registrar's Signature NOV 3 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3804 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4150AM 11 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Itimos & 5. Social Security Number 8. Date of Birth (Month, Day, Year) 07 07 1949 If Under 24 Hrs 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Funeral 1**X** M 2 □ F 62 Yrs. 217-50-3015 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral CEDARCROFT 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE ECURITY 2 OFFICER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JOSEPH J. FUGG EA THA MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROAD. BALTO, MD. 21239 F066 SISTER) YLVIA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 12/5/11 CROWNSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Furth Sept ce Licensee 22. Name and Address Facility VAUGHN GREENE FUNELAR SCVS YORK RIAO. BATTIMORE, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ aro) nona disease or condition 21/12/1 Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been in 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Hospital: 1 Yes Other: Certificate: To 1 MInpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Many er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 34359 (OHIO) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a Boulewood, Balt more, Maryland

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Nov. 25. 2011 Physician/ CHARLES JOSEPH FOGLE 2:31 Рм Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Center for Hospice Care Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days 214-50-7322 Director 1 🕱 M 2 🗆 F 64 July 27, 1947 Maryland show na State 10h Count 10c. City, Town or Location 0d. Inside City Limits the Maryland Director items 23a or 28a-f s her must be notified Maryland N/A Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 106 East Clement St.. 21230 USA death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. or þ 1 Never Married 2 V Married Yes, Giv Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. White "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation Kind of Business/Ir 16b. Kind of Business/Industry
Archdiocese of Baltimore (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Stationary Engineer 12 other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I is marked o Earl D. Fogle ပ Viola M. Novak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other tra Jean Marie Fogle 106 East Clement St., Baltimore, Maryland (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/29/2011 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery Baltimore, Maryland 21. Signature of Funeral Gervice Licensee Kevin E Ecker M00175 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metaltali Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Pregnant at time of death 2 No detached 9 Unknown 9 | Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 2 2 No I ☐ Yes Yes I or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Nother (Specify) within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No filled in by the I Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical 29a. Certifier 1 🖳 🗲 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d, Date signed (Month, Day, Year) 7104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUTTE KUMAR 6701 CHA 25 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29^{Bay} ELLEN D. FOSTER NÖV. 201°1 6:30A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE MUINOMIT <u>STELLA MARIS</u> Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^(ear)1<u>925</u> 1 □ M 🛛 🖾 F Months Days Hours June 20 **Director** 86 217-22-1122 Maryland Usual Residence of Decedent if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Director 10c, City, Town or Location 10d. Inside City Limits Maryland Baltimore City Baltimore City 1XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6503 Fairdel Avenue 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 🗌 Widowed 4 🗌 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Health Nurse 6 yrs. Nursing Industry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ellen Merritt Vincent James Roland Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6503 Fairdel Avenue Baltimore, Maryland Susan Richardt Maxa (POA) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Pk. 12-3-2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore. Md. 22. Name and Address of Facility Lassann Funeral Home 21. Signature of Funeral Service Licenses 7. 7401 Belair Rd. Baltimore, Md. 21236 Zassahr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Peath shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Year 9 Unknown 9 Unknown **Director:** After this certificate has been signed by in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1XNatural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS, CRNP 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

NOV 3 0

NOVEMBER

FOSTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hn Edward	Fra		ovich State of Maryland / Department of Head- I-For State Certificate of Dea		tal Hyg		2	0 1	1 3804
Ωhvoi	ioio		Registrar 1. Decedent's Name (First, Middle,Last)		2.	Re Date of Deat	g. No.		3. Time of Death
۱۱۷۶ edical Exa			John Edward Franetovich			^{Month} Vovember	Day Year 21, 2011		0815 hrs
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16 n 72 h	ical	plet	Elementary/Secondary (0-12) College (1-4 or 5+)				 m: L3 = T	·	
5-003(led within Hygiene.	event, the Medical Examiner must be notified at once.	Completed	17. Father's Name (First, Middle, Last)	Underwrit		irst. Middle. M	Title I	nsui	rance
a filed	th th	_	Florio Nicholas Franetovich				eth Hene	miei	_
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene.	c eve	ᆰ		ess (Street and Num					
and 2 should lealth and Me tem 27 is ma	umaç			regor Way,	Bel 2	Air, M			
L and Heal	er tra	ſ	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (for crematory or other pla		D	ate	20c. Location - (City or T	own, State
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma	뒴		4 Donation 5 Other Specify: Bel Air Memo:	rial Gdns.	11-	26-11	Bel Air	c, M	aryland
kalti rmit. spartn sports	iri	Ī	21. Signature of Funeral Service Licensee 22. Name a MCCOI	and Address of Facility Mas Funera	1 Hom	e, P.A	١.		_
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68 certifi	se as	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal dea 4 Pregnant at time of death 5 Other (S		c pregnancy	/	Month	Da	ay Year
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12		ł	30. Name and address of person who completed cause of death (Item 23a)				l		
r			*	nore Street, Balti	imore, M	D 21223			
		ate	31. Date filed (Month, Day, Year) 32. Fegistrar's Signature 3. January 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature 32. January 33. Date filed (Month, Day, Year) 32. Fegistrar's Signature 33. January 33. Date filed (Month, Day, Year) 33. Date filed (Month, Day, Year) 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Date filed (Month, Day, Year) 36. Date filed (Month, Day, Year) 37. Date filed (Month, Day, Year) 38. Date filed (Month, Day, Year) 39. Date filed (Month, Day, Y	1					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Registrar	Item State of	Marylar er	nd / Depá Cer	artment tificate	of De	01114í eath	nd M	ental Hy	giene Reg. No. 2	01	1 3804
	Physicia	an/	1. Decedent's Name (First, Midd) Nancy	B. Gardne	r						2. Date of De	er 23,	2 (Y9 ₽r₁	3. Time of Death 12:15am м
74	Medi Exami		4a. Facility Name (if not institution				4b. City, To	wn, or L	ocation o			4c. County		112:13alli M
7	<u> </u>		Fairhaven Hea						vi11∈					rroll
П	Funeral Director		5. Social Security Number 003–16–7129	6. Sex 7.	Age (In yrs. I	last birthday) Yrs.	If Under 1 Months I		If Under 2 Hours		8. Date of Bir A <i>lphonth, D</i> a	th y, Ye47925	9. Birth Coun	olace (State or Foreign try) NH
	od now at	Ļ	Usual Residence of Decedent 10a. State 10b. County	,	100 0	n. Tourn and a	noting.							
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mo m	Page 1 nent of ant: If it		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (8	3 ☐ Removal from Sta Specify)	ate c	emetery, crem	atory or othe	r place)	on !11	Dat	1	20c. Location - Sykesv:	•	
Baltimore, Maryland 21215-0036	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service I	Licensee		22.	Name and A							CHAPEL, PA
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	inysician/		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition					,,				001,		Approximate Interval Between Onset and Death
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P.O. Box 687	death certificate be executed ne attending physician and ed for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon	h 2 🗌 Feta	ldeath 3 🔲	Ectopic preg						e of delive	•
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	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 Certifying	Physician: To the best	of my knowle	edge, death oc	cured at the	time, da	te and pla	ace, and d	ue to the cau	se(s) and manne	r as stated	
;	the Hithin 24 the Formplete		(Grieck Z 🗆 Medical E	xaminer: On the basis of Nurse Practioner: To the	examination	and/or investig	ation, in my cath occurred	pinion, cat the tin	death occu ne, date ar	irred at the	time, date an	d place, and due cause(s) and mar	to the caus	se(s) and manner stated, red.
	# 3 F 8		► Land	1D				3 H	84°	9	2	9d. Date signed	ber	23 2011
	(9)		30. Name and address of person v	who completed cause of	death (Item	23a) (Type, Pri	n#\	521		? /dk	7 AL.	MI	201	23 2011 784
	Stat	е	31. Date filed (Month, Day, Year) NOV 3 0 20	32. Regis	trar's Signatu	ire				, 104	4) DU	9	-	
	Registra		1101 3 0 20	Canera	A.	Marke	1	_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fb 2922 12-13-11 yt. State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Nov. 2011 25, 5:55 PM Ethel Mae Gibson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll 841 Streaker Rd. Sykesville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Min. **Director** 217-22-1942 1 M 2 X F 89 7/14/1922 SC Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10h County 10c. City, Town or Location Director 10d. Inside City Limits notified MD Carroll Sykesville 1 Yes 2 X No ö 10e. Street and Number 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Funeral 841 Streaker Rd. 21784 USA items ? and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Force Black, White, etc. ō þ 1 Never Married 2 Married Yes Yes, Give 2 K No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 X Widowed 4 Divorced Completed Specify: Black. Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 3 Springfield Hospital ulth and Mental Hygie 27 is marked other r traumatic event, th Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Gibson Simon James Minnie Joanna Drakeford 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Joann Miller/Cousin 4414 Parkmont Ave., Baltimore, MD 21206 other Baltimore, 20a. Method of Disposition cof P c If if 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Department o Important: If any injury or once. ō cemetery, crematory or other place) 4 Donation 5 Other (Specify) Fairview Cemetery 12/1/2011 Taylorsville, MD 21. Signature of Funeral Service Licensee ²² Name and Add ON of Equility Funeral Home & Crematory, P.A. 212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Arteriosclerotic cardiovascular disease Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exam and the burial-tra resulting in death) Last Due to (or as a consequence of): physician Medical that the death certificate be Box 68760 attending pl IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 1 ☐ Yes 2 XNo 9 ☐ Unknown the 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertension Completed 1 Yes 2 No 3 Probably 4XX Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical å 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 XNo Other: <u>م</u>| 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending (Month, Day, Year) 124 hours after death. e Funeral Director; Aft letely filled in by the fur work' Accident Investigation M 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completely filled ii Medical 29a. Certifier Accritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who comple Howard G. Lanham,

backer

32. Registrar's Sig

D17040

mpleted cause of death (Item 23a) (Type, Print)
n, M.D. 215 Washington Heights Medical Center

November 28,

Westminster, MD 21157

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, perFH, G921, 11730/2011, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10:45 PM Eyans 21 Medical 4b. City, Town, or Location of Death Facility Name (if not institution 4c. County of Death **Examiner** 1016 140) 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Director 1 □ M 2 🕶 F 5 12-27-1965 MD 28a-f show 10c. City, Town or Location 10d. Inside Gity Limits within 72 hours after death with the Maryland aţ 10b. County Director must be notified timore 1 Yes 2 No 10g. Citizen of What Country? ò Funeral "natural", or items 23a edical Examiner must be 216 18 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) nemolou Be Eather's Name (First, Middle, Last) မ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked rva 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Druid Ridge injury or 1 Burial 2 Cremation 3 Removal from State crematory or other place, 4 Donation 5 Other (Specify) ure of Funcial Service Licens any 5151 Balto. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or injury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s autopsy 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific.
completely filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of Natural 28d, Describe how injury occurred injury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death, (Item 23a) (Type; Zrint) 6 V filed (Month, Day, Year) 32. Registrar's Signature State 3 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Figure All Copies Are Legible. amend 20b, per fh, g922 12-2-1 Fsm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decement's Name (First, Middle, Last) 2. Date of Death Day Physician Vear Month Gues Lee NOV 27 2011 /Medical 4c. County of Death 4a. Facility Name (# not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month Day) 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**™**M 2□ F 265-26-8817 11-10-1926 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must han mare han 10b. County 10c. City, Town or Location 10d. Inside Çity Limits Baltimore 1 Nes 2 No Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Omg St. Fig. Nother Name (First, Middle, Maiden Surname) pina Father's Name (First, Middle, Last) Be oues ပ oreen 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5010 Norward Baltimore, MD 21207 Michael L. toste Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 Removal from State Baltimore, MD 12-6-11 King Park 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Greene Funeral Services 5151 Bulto. Nat'1 P: 16 (21229) 21. Signature of Funeral Service Licensae Leene vaugh 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Septor Shee Due to (or as a consequence of): Shack au disease or condition resulting in death) Medical -xaminer Veerbotes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical the, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Congrestive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page 2 perform 1□ Yes 2 100 Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this o 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Deatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 MS PATEL CHINTAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 3 0 2011 Denve & DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38049 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month a Trana 6:50 PM 2011 Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death Baltimore hrist owsor Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. **Director** 1 □ M 2 € Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at Director 10c. City, Town or Location 10d. Inside City Limits Yes 2 No altimore ms 23a or or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 arrington items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 2 No ö þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify. 1ack "natural" Completed 3 Widowed 4 ☐ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the traumatic event. Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surr ပ and lis mis Informant's Name/Relationship (Type, Print) ral Route Number, City or Town, State, Zip Code) f Health 7608 eserve Page 1 and 2 floria ircle 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o once. jo 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Spe MI Funeral Service 22. Name and Addre ss of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Metastatic Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at d be detached for g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 400 Other: ျပ 1 Inpatient 2 ER/Outpatient this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No After t Certificate: 28d. Describe how injury occurred 1 Matural injury 5 Pending ours after death. eral Director: Aff filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tille of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		1- For State Registrar	Certificate of	Death		Re	g. No. 201	1 38050
Physical Exar		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month November	Day Year 25, 2011	3. Time of Death 1101 hrs
		Sacility Name (if not institution, give street and number) Clearwater Court	ľ	4b. City, Town, o Middle Riv	r Location of Deat er	th	4c. County of Death Baltimore Cou	
Funera Directo		213-60-5291 XX _{M 2□F} 58	yrs. last birthday) Yrs	If Under 1 Ye Months De			2 1953 Foreig	thplece (State or in Md . untry)
p po p	4 _	Usual Residence of Decedent 10a. State 10b. County 10c. Maryland Baltimore	City, Town or Locati		more Cour	nty		10d. Inside City Limits 1 Yes 2 No
the Marylan n or 28a-f s	Director	10e. Street and Number 1 Clearwater Ct.		10f. Zip Code	21220	10	g. Citizen of What Cour USA	ntry?
or items 23a or 28a-f show	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Yeer	lf Y	es, specify Cuba	in, Mexican, Puert	Specify Yes or No- o Rican, etc.)	14. Race - Ameri White, etc. Specify: Whi	can Indian, Black,
Jimore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Late: If item 27 is marked other than "matural", or items 23a or 28s-f she mother teams its part of the Medical Framinary.	leted by	or Dates:	d) 16a. Deceden during mo	ost of working lif	ation (Give kind of e. DO NOT use re		16b, Kind of Business/I	ndustry
21215-0036 utd be filed within 7 Mental Hygiene.	Completed	12th grade N/A 17. Father's Name (First, Middle, Last) Norman Alva Grubb	Carp	penter	18.Mother's Nam Mavbel	e (First, Middle, M	Coastal E Maiden Surname) beth Scarbo	-
AD 212 2 should be and Menta 27 is marke	To Be	19a. Informant's Name/Relationship (Type, Print) Carol J. Grubb (Wife)	_		et and Number or	Rural Route Num	ber, City or Town, State	, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If them 27 is marked other than injury or other transmitte over the Medical Applications of the present it is well as Medical and Injury or other transmitter over the Medical Applications of the present it is well as Medical and Applications of the present and applications of the present and applications of the property o		4 Deurick 2 V Cromption 2 Democratican State	Ob. Place of Dispos crematory or oth Metro Cre	ner place)		Date	20c. Location - City or Baltimore,	_
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Division of Vital Records, P.O. Box 68760, To the Boopin or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Purearal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director nave 2 should be detached for use as the burial -transic completely filled in by the funeral director nave 2 should be detached for use as the burial -transic.	sician	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of past 1 Live birth 4 Pregnant at time of past 1 Ves 2 No 9 Very Norm 1 Very Norm 1 Ves 2 Very No 9 Very Norm 1 Very Norm 1 Ves 2 Very Norm 1 Ves 2 Very Norm 1 Ves 2 Ves	2 Fet	tal death 3 ner (Specify)	Ectopic pregn	ancy	23d. Date of delivery Month D	pay Year
P.O. E es that the digned by the detached	ē E	Part II. Other significant conditions contributing to death but n	not resulting in the u	inderlying cause	given in Part I.		pacco use contribute to	
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Division Hospital or Attend 24 hours after death Funeral Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined (Specify) Townho	ouse / Rowhous	se		or Town, St 1 Clearwater C	ourt, Middle River, N	ID
Div To the Hospital or within 24 hours afte To the Funeral Div completely filled in	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.		ion, in my opinio	n, death occurred		ind place, and due to the	e cause(s)
	2	29b. Signature and title of certifier		29c. Licen	M.E.		November 26, 20	
√		30. Name and address of person who completed cause of death (ing Li, MD Assistant Medical Examiner 90)	00 W. Baltimor	e Street, Ba	timore, MD 2	1223		
	State	31. Date filed (Month, Day, Year) 32. Registrar's Sa	nature					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5. 2<u>011</u> Physician/ Suzanne Godfrey 7:01 P November 26, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Renaissance Gardens If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Months Hours Min. (Month, Day, Year) Director 219-28-2285 Usual Residence of Decedent show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 ☐ Yes 2 XXNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 8810 Walther Blvd Apt. 201 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 \square Never Married 2 \square Married 1 Yes 2 No 1 ☐ Yes 2 ☐ No Specify: White Specify: 3xx Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Secretary Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Corydon P. Gowman Gladys D. Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Heinlein (Daughter) 214 Hopkins Road Balto, MD 21212 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/29/11 Glen Burnie, MD . Signature of Funeral Service Licensee Burgee Henss Seitz Funeral Home, 3631 Falls Road Balto, MD 2121 23a. Part 1. Enter the disease, or como¹ cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset —d Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) cance Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence org. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending hours. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 ☐ Unknown 1 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? injury 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗀 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29d. Date signed (Month. Day, Year) 27th 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkulli V and vone FOO M

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Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Giles November 2011 4:33 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7213 Wright Road Hanover Anne Arundel Social Security Number If Under 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 220-09-5707 **Director** 1 X XM 2 - F 93 10-11-1918 MD Usual Residence of Decedent 28a-f show 10a. State the Maryland Director 10c. City, Town or Location notified at 10d. Inside City Limits 1 Yes 2 XXNo MD Anne Arundel Hanover 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country event, the Medical Examiner must be Funeral with 23a 7213 Wright Road 21076 United States items . Page 1 and 2 should be filed within 72 hours after death irrent of Health and Mental Hygiene. Fant if item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner m. lury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗶 Yes 2 🗌 No If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify. Completed 3 Nidowed 4 Divorced WW-2Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Owner/Operator Automobile Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Giles Jennie Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John D. Giles - son 1424 Chazadale Way, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11-28, 2011 Glen Burnie, Maryland of Fune 21. Signature 22. Name and Address of Facility Gary L. Kufman Funeral Home at MMP, Inc, 7250 Wash Blvd, Elkridge, MD 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tra Due to (or as a consequence of): attending physician for use as the buris Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIRRILLATTON 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 2 No ٩ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 execcious res State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 23 chr157 Physician Elizabeth 10:45 PM 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth 01/08/1931 **Funeral** Months Days 1 🗆 M 2 😾 F 213-26-0962 80 Vírginia **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 23a or 28a-f show notified at 1 XYes 2 No MD Director n/a Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number Examiner must be 5009 Frankford Avenue 21206 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" "" any injury or other traumatic event." 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Day Care Provider Family Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Freddie Trayham Hattie Pettis ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Macheal Franklin- Daughter 2087 Titan Terrace Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Woodlawn Cemetery 12.02.2011 Windsor Mill, MD 21. g of Funeral S ne and Address of Facility L. Williams Funeral Directors, P.A. Park Heights Ave Baltimore, MD 21215 ture Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma rancreat **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner cardiovascular pertensive The law requires that the death certificate be executed use as the burial-tra Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed' 2 🗌 No 2 No 1 Tes Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Inpatient 2 ER/Outpatient al or Attending Physics after death. 1 Yes 2 No 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 28b. Time of 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 🛮 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 23,2011

State Registrar

DHMH 17 Rev 1/2001

020676

Bay 160 Hastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#7perFH, G922, 12/14/2011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar 38054 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HUFF NOAH 28,2011 7:25 Vovember Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 XM 2 □ F Months Hours **Director** 243-20-3626 65 1926 NORTH CAROLINA 85 Yrs Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified 1 🙀 Yes 2 🗌 No PRINCE GEORGE'S CAPITOL HEIGHTS ō 10e. Street and Number ms 23a or must be 10g. Citizen of What Country? Funeral 817 BOOKER PLACE 20743 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner ō þ 1 Never Married 2 Married Black, White, etc. 1 Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specif AFRICAN AMERICAN "natural" Completed 3 Widowed 4 Divorced Year or Dates nt of Health and Mental Hygiene.

If item 27 is marked other than "natul or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4uft, Noat GOVERNMENT SUPERVISOR Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ NOAH HUFF MARY Ε. ROGERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 BOOKER PLACE CAPITOL HEIGHTS, MARYLAND 20743 VAOLA HUFF/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) CHELTENHAM, MARYLAND MD VETERANS CEMETERY 12/8/2011 21. Signature of Funeral Service Licenses J.B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph sician/ Wimonor Medical **Examiner** Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? jo Day Year Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown the detached 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Bluenmero 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available has autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No certificate 25. Was case referred to edica Be 26. Place of Death (Check only one) examiner? Hospital: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at eral Director: After filled in by the funer 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сопріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10050951)41D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenilworth Due Stute 2400 Reverda MD20737 5. 6510, GILL

State

Registrar

32. Registrar's S

NOV 3 0 2011

Amend #5,17, per Fh G922 12/5/1 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death REV. EARL DIRK HOFFMAN, SR. Physician/ Month 26. 11:30 P M Nov. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 600 Light St., Apt. 211 Baltimore N/A 5. Social Security Number **Funeral** 6 Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 215-24-4421 1 K M 2 🗆 F Months Davs Hours Min. (Month,-Day, Director 83 1928 Maryland Jan, Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Light St., Apt. 211 21230 USA 72 hours after death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces? o. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify "natural" 3 X Widowed 4 Divorced White Specify event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Episcopal Priest Diocese of Maryland Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hys
Important: If item 27 is marked oth
any injury or other traumatic event, Philip 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Phillip Hoffman Maria Antoinette Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Dirk Hoffman, Jr. (Son) 4212 Willshire Avenue, Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation J5 ☐ Other (Specify) Cedar Hill Cemetery 11/30/2011 Baltimore, Maryland 21. Signature of Juneral Service Licensee Kevin E Ecker M00175 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Phusician/ rtery disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a nsequence of attending physician and for use as the burial-transit that initiated events the Hospital or Attending Physician: The law requires that the death certificate be exe resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 2 No ate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed?

Yes 2 No 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita မှ 1 🗌 Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Director: A Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar		State of M	laryland	d / Depa <i>Cer</i>	artment of F tificate of D	lealth a Death	and M		giene Reg. No.		1 38	056
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Exan							4b. City, Town, or	Location o	of Death	120	4c.	County of De	ath	
Funer	al	BALT WAS 5. Social Security Number	6. Sex	T. AC	D CT		If Under 1 Year	If Under	24 Hrs	8. Date of Birt			ARUND	
Directo		219-52-9016		M 2 🕱 F	54	Yrs.	Months Days	Hours		Sept 1,	, Year) 1957		irthplace (State or country) Marvland	Foreign
and show	٥	Usual Residence of Deced	County		10c. City,	Town or Loc	cation						10d. Inside City	v Limits
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ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	\$	1 Never Married 2		Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates.	No		Yes, specify Cubar ☐ Yes 2 🛣 No		, Puerto F	Rican, etc.)		Black, Wh		
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, Ma id 2 sh salth ar n 27 is er trau		Kathryn C. Hu		(Daughte	er)		g Address (Street at Crystal Pa						ip Code) 21122	
Baltimore , cermit. Page 1 and Department of Hea Important: If item any injury or other		20a. Method of Disposition		moval from State	cer	metery, crem	ition (Name of atory or other place)		ate		ation - City o		
Baltimor permit. Page 1 Department of Important: If ii any injury or o	ál l	4 Donation 5 C	ther (Specify)		GLen		Mem. Pk.		1/28/				Maryland	
any Depr		0	/2	MO0175	-	22.	Name and Address 3204 Mountai	in Rd.,	Pasac	dena, Md	niak 1 . 211	runeral 22	Home, P. A	١.
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To the Hospital or Attending Physical Middle Attending Physical Prours after death. To the Funeral Director: After this completed filled in by the funeral display.	Medical	only one) 3 Cert	ifying Nurse Pr	On trie basis of ex-	amination ar	10/or investia	cured at the time, d ation, in my opinion, ath occurred at the ti	death acci	irrod at th	a tima data and	مممامراه	and alone to the land		ier stated.
5 ₩ ₩ C		29b. Signature and title of ce	retifier of	no			29c. License n		0			signed (Month		
12		30. Name and address of pe		leted cause of dea	ath (Item 23	la) (Type, Prin	nt)				-			
Sta		31. Date filed (Month, Day, Ye		37. Registrar	's Signature	han	301	1701/	D	K 96	EN	BAYLAL	4 2016	2/
Registr	ar	NOV 3	0 2011	Lecura	, p.	Full								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc g921 11-30-11 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar 201 38057 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HAMOSH MARGIT 11:40 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1104 Ryegate Road Towson 9. Birthplace (State or Foreign Country)
Germany Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min. Months 08/113/11933 Director 213-54-6163 78 1 □ M 2 🗓 F Usual Residence of Deced "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🏋 Yes 2 □ No MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9410 Balfour Court 20814 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify. Completed 3 Divorced 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Academic Medicine Scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည Jacob Katz Clara Heitner permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9410 Balfour Court Bethesda MD 20814 Paul Hamosh - husband Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/6/2011 Rockville, MD 4 Donation 5 Other (Specify) Parklawn Mem. Park 22. Name and Address of Facility M01163 Danzansky-Goldberg Memorial 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Jeath Immediate Cause (Final Hepstocellular Ph_sician/ Carcinoma disease or condition Medical resulting in death) Dul to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal deal ☐ Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy perform death? Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: daughter's ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 6 Nosidence 6 Other (Specify) 27. Manner of Death residence Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 5 \square Pending 1 Natural worl 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and Atle of certifis DIRECTOR,

Registrar

DHMH 17 Rev 06-2011

State

lan

asuna

2055 C.DONEHOWER, ND
31. Date filed (Month, Day, Year)

NUV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHUS HOPKIUS CAUCER CEUTER

MEDICAL UNCOLDGY

N23675

MD

BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charles Hartsoc	k, J	State of Man	-			Mental	Hygiene	2 (3 1 1	2005
Physicia	anl	Registrar 1. Decedent's Name (First, Middle Last)	Cer	tificate of	Deam		2. Date of De	Reg. No. 2		3805
Medical Exami		Charles Hartsock JR					Month October			Time of Death 1553 hrs
		4a. Facility Name (if not institution, give street and	number)	4	lb. City, Town, or L	ocation of De		4c. County of	Death	
		301 McMechen Street			Baltimore					
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs, la	st birthday)	If Under 1 Year	If Under 24	Irs. 8. Date of B	irth(MM/DD/YYYY)		lace (State or
Director		218-46-3178 1XM 2	65	Yrs.	Months Days	Hours N	Nov 3	, 1945	Foreign Count	w)Maryland
		Usual Residence of Decedent								
w any		10a. State 10b. County		Town or Locati				-		Od. Inside City Limits
Maryland 28a-f show	힏	MD	Ва	ltimore					1	Yes 2 No
Mary r 28s	Director	10e. Street and Number 301 McMechen Street #	500		10f. Zip Code	01017		10g. Citizen of Wha	at Country	?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f shown aftic event, the Medical Examiner must be notified at once.						21217		USA		
× 2 2	Funeral		ecedent Ever in U.S Forces?	S. 13. Was	Decedent of Hisp es, specify Cuban,	anic Origin? (Mexican, Pue	Specify Yes or Norto Rican, etc.)	o- 14. Race - White,		Indian, Black,
ter de		3 Widowed 4 Divorced If Yes, Give		1	Yes 2 X No	anocifu:		C===#		
urs af tural	d b	or Dates: 15. Decedent's Education (Specify only highest of			's Usual Occupatio		of work done	Specify: 16b. Kind of Bus	whit	
72 ho	Completed		(1-4 or 5+)	during mo	st of working life, [DO NOT use r	etired)			aou y
036 ithin ne. fedic	핕	12	4	stati	onary sa	les		Lucas	Brot	hers
5-0 led w Hygie		17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Surname)		
121 lbe fi ental]	a	Charles Dorton Hartso	ck Sr				Nellie M	ay Collir	ıs	
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygene. n 27 is marked other than numatic event, the Medica	٩	9a. Informant's Name/Relationship (Type, Print)						mber, City or Town,		p Code)
md 2:	ŀ	David Markovsky/frien 20a. Method of Disposition			IcMechen		#1208 B	altimore,		21217
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter injury or other traumatic event, the Medical Examiner must.		1 Burial 2 Cremation 3 Remova		ematory or oth		etery,	Date	20c. Location - C	Jity or 10	wn, State
timent trant:		4 Denation 5 X Othe Specify: in	state							
Bal permi Depar injur	l		Director	Sta	ame and Address o te Anator	of Facility Ny Boan	d 655 W	Baltimo	re S	treet
Physician	1	3a. Pan L. Enter the disease, or complications that	caused the death. I	Ba1 Do not enter the	timore, Ne mode of dving, si	VID 212	0 1	est shock or hear		Approximate Interval
/Medical		failure. Vist only one cause on each line.	erotic Cardiova				,			Between Onset and Death
Examiner		and a second the second to the	a consequence of):		350				-	
		Sequentially list conditions, b								
-	Ē	ause. Enter Underlying Cause	a consequence of):							
=	Examiner	Disease or injury that initiated	a consequence of):	:					$\overline{}$	
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be exclusion unial -	dical	UNPENDED AMENDE)							
Sox 6876(death certificate te attending phys		th Mas decedent program at in the	s, outcome of pregna			7		23d. Date of de	_	
certing ending	Ciar	past 12 months?	ι ρίπη gnant at time of deat	- =	aldeath 3 er (S <i>pecify</i>)	Ectopic preg	nancy	Month	Day	Year
Box 6876 e death certificate the attending phy ed for use as the b	Physician/M	Yes 2 No 9 Unknown 9 Unk	nown	Our	si (opecity)					
Division of Vital Records, P.O. B tal or Attending Physician: The law requires that the de rs after death. al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached.	절	art II. Other significant conditions contributing	to death but not res	ulting in the un	derlying cause give	en in Part I.	1	bacco use contribu		
B, P	象						1 ✔ Yes	s 2 No 3	Probabl	y 4 Unknown
ords, w requires to been a should	Completed						24a. Was autop			sy findings available pletion of cause of
tal Recc	E							rmed? dea	ath? Yes	2 No
tal Rection: The certificate	a B	5. Was case referred to medical			26.Place of	f Death (Chec				
Vit hysic this o	ပ	examiner? 1 ✓ Yes 2 No	Inpatient 2 E	R/Outpatient	3 DOA OI	ther Nurs	ing Home 5	Residence 6	Other: Sc	ene
n of ding Ph	٦	1 Notice (Mor	e of Injury 2 th, Day, Year)	28b. Time of Inj			28d. Describe	now injury occurred		
Attend r death ector: by the	j ă	2 Accident Investigation	4			s 2 No				
DIVIS pital or A ours after teral Dire	Certification:	Suicide Could not be	ice of Injury - At hom	ne, farm, street,	factory, office buil	ding, etc.	28f. Location (S or Town, S		or Rural F	Route Number, City
Cospita hours unera ly fille		Homicide (Special								
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the b		check only 1 Certifying Physician: To the b 2 Medical Examiner: On the basi	of examination and	, death occurre I/or investigatio	nd at the time, date n, in my opinion, d	and place, ar leath occurred	id due to the caus at the time, date	e(s) and manner as and place, and due	s stated. to the ca	use(s)
To with	ğ -	and manner 3b. Signature and title of certifier	stated.		29c. License r			29d. Date signed		
		All land	D		O.C.M.			November 1,		,,
	-	D. Name and address of person who completed ca	use of death (Item 2)	3a)						
			edical Examine		Baltimore Stre	eet, Baltim	ore, MD 2122	3		
	_		egistrar's Signature	1 7	11					
Registr	ar	NOV 3 0 2011 L	week B	par						

ORIGINAL

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Albert Bernard H		Si 1- For State Registrar	ate of Maryla		artment o		d Mental	Hyg		Reg. No.	201	1 38	805
Physicia	n/	1. Decedent's Name (First, Midd		-					Date of Dea Month	ath Day	Year	3. Time of Dea	
Medical Examir	ier	Albert Bernar 4a. Facility Name (if not institution		umber)		4b. City, Town, or I	ocation of D		October 2	21, 2011	ity of Deat	1414 hrs	
		1 West Conway St	, •	•	-	Baltimore					,		
Funeral	\neg	5. Social Security Number	6. Sex	7. Age (In yrs. I		If Under 1 Year		-		•	YY) 9. Bir Foreig	thplace (State o	r
Director		213-54-2615	1 → M 2 → F	6:	2 Yrs	Months Days	Hours	Min.	Apr 3	, 1949	Co	untry) Mary	1and
Å:		Usual Residence of Decedent 10a. State 10b. County		Inc. City	, Town or Locat	ion						10d. Inside Cit	n. Limite
T		MD TOD. County		Toc. Oity,	Baltim							1 X Yes 2	•
faryland 28a-f sho	휞	10e. Street and Number			Daltin	10f. Zip Code			14	10g. Citizen of	What Cou	21	
0036 within 72 hours after death with the Maryland giene. rer than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	Director	1 W. conway S	treet				1201			USA		, .	
with 1		11. Marital Status		cedent Ever in U		s Decedent of Hisp						ican Indian, Blac	ck,
death or iter	Funeral	1 Never Married 2 M	arried Armed Fo	orces?	If Y	es, specify Cuban,	Mexican, Pu	erto Ric	an, etc.)	W	hite, etc.		
s after ral",	۵		orced If Yes, Give Yea or Dates:			Yes 2X No				Specif	,·	Lack	1
natu Eran		15. Decedent's Education (Spe Elementary/Secondary (0-12)	cify only highest grad			it's Usual Occupations of working life.				16b. Kind of	Business/	ndustry	unk
36 hin 72 than edical	릙	12	4	-4 OI 3+)									
15-0036 Iled within 72 hour Hygiene. d other than "natt	Completed	17. Father's Name (First, Middle,				1	8.Mother's N	ame (Fi	rst, Middle, I	Maiden Surnar	ne)		
	å	Albert Hill						-	Brac				
Should and Me	의	19a. Informant's Name/Relations				Address (Street							_
≥ da alth	ŀ	Marvin Hayes/ 20a. Method of Disposition	cousin	1 20h		Reisters			Balt	20c. Locatio		21215	
Baltimore, M Permit. Pages 1 and 2 Department of Health Important: If item 2 njury or other traum		1 Burial 2 Cremation	3 Removal fro		crematory or ot		letery,	D.	ale	20C. Locatio	II - City of	Town, State	
	ŀ	4 Donation 5 X Other Sp	pecify: in st	tate	I no a		45.00						
Balt permit. Depart Impor injury	Į	21. Signature of Funo I Servi				lame and Address ate Anato						Street	
Physician	1	23s Part I. Enter the disease, or	complications that ca	aused the death	. Do not enter the	Ltimore, ne mode of dying, s	MD 21 such as cardia	201 ac or res	spiratory arr	est, shock, or l	neart	Approximate	
/Medical	1	failure. List only one cause Immediate Cause (Final disease		nsive A	therosc	lerotic (Cardio	vasc	ular	Disease	e	Between Ons Death	
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687 ertifica ding p	a l	23b. Was decedent pregnant in the past 12 months?	1 Live bi	irth	2 Fe	tal death 3	Ectopic pre	gnancy		Month		ay Ye	ear
Box 68760, e death certificate be the attending physical for use as the bun	Physician/Me	1 Yes 2 No 9 Unk	nown 9 Unkno	ant at time of de	ath 5 Ot	ner (Specify)							
D. B. tr the de by the ached for		Part II. Other significant condit			esulting in the u	nderlying cause giv	ven in Part I.		23e. Did to	obacco use cor	ntribute to	the cause of dea	ath?
ires that the signed by	<u></u>				-				1 Yes	2 No	3 Prot	ably 4 🗹 Unk	known
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of Vital Records, ng Physician: The law require ufter this certificate has been si meral director, page 2 should b	0 20	examiner? 1 ✓ Yes 2 No	Hospital: 1 Ir	npatient 2	ER/Outpatient	3 DOA	other Nu	rsing Ho	ome 5	Residence 6	✓ Other	Scene	
After uneral		27. Manner of Death	28a. Date of	of Injury , Day, Year)	28b. Time of Ir	njury 28c. Injury	at Work?	280	I. Describe I	how injury occu	птед		
ttendi death. ttor:	달	Natural 5 Pend 2 Accident Inves				1 Ye	s 2 No						
Division pital or Attendio ours after death. eral Director: A	Certification:	3 Suicide 6 Could	d not be 28e. Place	of Injury - At ho	ome, farm, stree	t, factory, office bu	ilding, etc.	28f.	Location (S or Town, S		ber or Ru	al Route Numbe	er, City
ospita hours incral		4 Homicide	(opcony)									_	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bine.	<u>ië</u>	(Check only Certifying Pr	nysician: To the best miner:On the basis o										
To with	E	29b. Signature and title of certifie	and manner st			29c. License						th, Day, Year)	
		TO 1 11	. 1/	0 21		O.C.M	l.E. 00	ME		October 2	22, 2011		
	-	30. Name and address of person	who completed caus	e of death (Kem	23a)		_						
		Theodore M. King, Jr.,				900 W. Baltimo	ore Street,	Baltir	more, ME	21223			
Star Registra	_	31. Date filed (Month, Day, Year)	2011 32.	gistrar's Signatu	1 km	Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ November 2011 5:00 M. Eleanor Hall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Brighton Gardens 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 217-24-7211 **Director** 85 May 11, 1926 Yrs MD Usual Residence of Decede r 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland 10a. State Director Howard Columbia 1 Yes 2 No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ò items 23a or ner must be n Funeral USA 21045 7110 Minstrel Way death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Force Black, White, etc. ō 1 Never Married 2 Married Yes 2 X No by Maryland 21215-0036 72 hours after White 1 ☐ Yes 2 X No Specify: If Yes Give Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Public School Systemlife DO NOT use retired) other than of the and Mental Hygiene.

27 is marked other than retraumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Howard County Counselor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Herbert Elmer Hall Rosalee Earp permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Phelps/ Nephew 10790 West Crestview Lane, Laurel, MD 20723 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November cemetery, crematory or other place 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Mt.Zion UMC Cemetery 29, 2011 Highland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. Signature of Funeral Service Licenses any Ken Skile 313 Talbott Ave., Laurel, MD 20707 M01053 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician years a Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ò Dav Pregnant at time of death i signed by the at Id be detached fo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Congestive Heart Failure Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an Atrial Fibrillation autopsy has page certificate 1 Yes 2 X No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence &X Other (SpecifAssisted Liv. 2XX No 1 Inpatient 2 ER/Outpatient 3 DDA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined

State

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

Harry Li, MD, Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

1XXcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

8600 Snowden River Pkwy, #301, Columbia, MD 21045

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D56531

29d Date signed (Month, Day, Year)

November 28, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ November 23 Frances H. Haines 2011 1:00 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4h City Town or Location of Death 4c. County of Death 3464 - 6th Street Apt. A Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 8. Date of Birth **Funeral** 99 Months Hours 0472071912 216 48 8631 **Director** Usual Residence of Decedent or 28a-f show notified at show. 10a State 10h County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 3464 - 6th Street Apt. A 21225 U.S. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Curtis Wright Marietta Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Haines / Daughter 3464 - 6th Street Apt. A Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/29/2011 4 Donation 5 Other (Specify) Cedar Hill Cemetery Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ DIABETE disease or condition 1can Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of impury that initiated events Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physician thed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 3 Ectopic pregnancy 5 Other (specify) ___ Month Day Year Pregnant at time of death detached f Unknown 9 Unknow s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy death? this certificate Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 Natural 5 Pending filled in by the Accident Investigation 3 Suicide 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital on within 24 hours aft To the Funeral Dir Medical Learnifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed 2 Medical Examiner: On the basis of examination and/or investig 3 Certifying Nurse Practioner: To the best of my knowledge, de (Check only one) eath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 4600 RITHUISHYMMY AFULLBATEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2011 1 25 8:25 PM <u> Arthur Joseph Hirschberg</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard <u>Gilchrist Hospice of Columbia</u> Columbia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Min. (Month, Day, Year, 132-05-0868 1 **X** M 2 □ F 92 1919 New York 01 24 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Columbia Maryland Howard 10e. Street and Number Og. Citizen of What Country? United States 10f Zip Code 6372 Burnt Mountain Path 21045 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates. 1943–46 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: WHITE Specify. 3 X Widowed 4 Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dairy Engineer 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Sutherland David Hirschberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6372 Burnt Mountain Path, Columbia, MD 21045 Paul Hirschberg - SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 11-28-2011 $|_{ m Baltimore}$, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematory INC Skinature of Funeral Service Ocer 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) cerebye 1100 Due to (or as a consequence of) Weeks if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Ph sician/ Medical **Examiner**

Physician/

Medical

10a. State

Director

Funeral

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Completed

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other traumatic

Department of Important: If is any injury or conce.

Maryland 21215-0036

Baltimore,

physician and s the burial-transit Division of Vital Records, P.O. Box 68760 as use Į. signed by page 2 should

this certificate has

Hospital or Attending Physician: To the Funeral Director: After completely filled in by the funer 24 hours

Physician/Medical by Completed Be မ Certificate:

tension 25. Was case referred to medical 2 No 1 🗌 Yes 27. Manner of Death 1 Natural 2 Accident

29b. Signature and title of certifier

3 Suicide 4 Homicide

29a. Certifier

IF FEMALE:

5 Pending Investigation

6 Could not be determined

Hospital:

1 Inpatient 2 I

28a. Date of injury (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

ER/Outpatient 3 DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Other:

28c. Injury at

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

performed?

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

D00606 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LANE

26. Place of Death (Check only one)

1 Yes 2 No

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death Glen Burnie Health&Rehabilitation Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 1 M 2 7 F Davs (Month, Day, Year) lar 29 1915 Hours 96 213-03-7540 Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location be notified at Director Maryland N/ABaltimore City 10e. Street and Numbe 0 10f. Zip Code 10q. Citizen of What Country? Funeral 23a 27 is marked other than "natural", or items 23 traumatic event, the Medical Examiner must 404 Rosecroft Terrace 21229 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Force Completed by 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ၉ Harry Carter Margaret Kane and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Buffington/Daughter 180 Ritchie Hwy., Apt. 213, Severna Park, MD 21146 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other placel Metro Crematory Inc. 11/22/2011 Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimor 23a. Part 1. Enter the disease, or competitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 299 Frederick Road, Baltimore, Maryland 21228 shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the attending p for use as t IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Rocords, Completed 24a. Was an s certificate has t lirector, pa e 2 s autopsy Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? or Attending Physician: Th 2 🗆 No Yes 2 N 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes s after death.
I Director: Af 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral D

completed filled i Hospital Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination allows investigation, many opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) YIS (1

Day

Year

Anne Arundel

United States

White

14. Race - American Indian.

Restaurant

Annapalus Ms 21401

Black White etc.

4c. County of Death

11:30pm

9. Birthplace (State or Foreign

Country Maryland

10d. Inside City Limits

1 X Yes 2 No

Tapa Death

State

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Robert King Hirzel	1- For State	S	ate of Maryla		artment of		Mental H	/giene	3 .5.5.	011 0006
Physician/	Registrar 1. Decedent's I	Name (First, Mido	lle Last)	Ce.	rincate or	Dealli	-	2. Date of Deat	eg. No.	3. Time of Death
Medical Examine	1000	` '	, ,					Month November		
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Funeral	5. Social Secur	rity Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birt	th(MM/DD/YYYY)	9. Birthplace (State or
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21215-0036 uld be filed within 72 Mental Hygiene. marked other than " c event, the Medical To Be Complet	17. Father's Na	me (First, Middle			I ABBOC		8.Mother's Name	(First, Middle, N		versity
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MD 21215-0036 d 2 should be filed within 7 d 2 should be filed within 7 in and Mental Hygiene. a 27 is marked other than unmaric event, the Medical TO Be Compile	19a. Informant	s Name/Relations	ship (Type, Print)		19b. Mailing	Address (Street	and Number or R	ural Route Num	ber, City or Town,	, State, Zip Code)
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Baltimore, MD 2 permit. Pages 1 and 2 shou Oepartment of Health and N Important: If iten 27 is n injury or other traumatic	20a. Method of		n 3 Removal fro		Place of Disposi cnen/anopypr∠sth	ion (Name of cem Creenator	etery, V	Date	20c. Location - 0	City or Town, State
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		n 5 Other S		1	Loudon		- 1	25/2011	Baltim	ore, Maryland
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Division of Vital Records, P.O. Box 6876/ pital or Attending Physician: The law requires that the death certificate cours after death. reral Director: After this certificate has been signed by the attending phy filled in by the funeral director, page 2 should be detached for use as the b Certification: To Be Completed by Physician/Me	Chronic	alcohol abus	е					1 Yes	2 No 3	Probably 4 V Unknown
Records, : The law requires fiftcate has been sign, page 2 should be Completed	ĺ							24a. Was a		ere autopsy findings available or to completion of cause of
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Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for u Medical Certification: To Be Completed by Physic	29a. Certifier 1 (Check only one) 2		hysician: To the best miner: On the basis o and manner st	f examination a						
F > F S	29b. Signature	and title of certifie			~ 1	29c. License	number		29d. Date signed	(Month, Day, Year)
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State Registrar	31. Date filed (A	Month, Day, Year)	32. Re	gistrar's Signatu	backer					

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. after 1 filem 27 is marked other than "natural", or items 23a or 28a-f show after 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1 filem 27 is marked other than "natural", or items 23a or 28a-f show and 1	4a. Facility Name (If not institution, given the Johns Hopkins	ip Hanna re street and number) lospital Sex 7. Age (In yes la 80 0) Washington S Apt 12. Was Decedent Ever in U.S Armed Forces? 1 Wes 2 No H'ves, Give Year or Dates: Education ade completed) College (1-4 or 5+) nna Sr (Type. Print) Daughter S	T. Town or Log Ba. T. Town or Log Ba. T. Town or Log Ba. Town Tour If a. Deced (Give k life. D COI	10f. Zip-Code 212.	Location of Death City If Under 24 Hrs. 8. Date (Mon) 0 5 / 0 5	of Birth th, Day, Yea 0 6 / 1 9 or No- c) light fr Middle, Maid	Citizen of What Cou USA 14. Race - Ameri Black, White, Specify: o. Kind of Business/li extile anufactu den Surname)	nplace (State or Foreigntry) S C 10d. Inside City Limit 1 X Yes 2 \(\subseteq \) N Intry? Introduction Indian, a ctc. A C k Industry
and 2 should be nied within 72 hours after death with the Maryland fleath and Mental Hygiene. Mary 1 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	5. Social Security Number 250 - 30 - 3915 Usual Residence of Decedent 10a. State MD 10b. County MD 10c. Street and Number 201 3100 Ellwood 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest green and the state of the sta	Sex 7. Age (In ys. Ia 86 10c. City 31 0 (10c. City 31 0	T. Town or Log Ba. T. Town or Log Ba. T. Town or Log Ba. Town Tour If a. Deced (Give k life. D COI	ation Itimore 10f. Zip-Code 212 Jas Decedent of Hir Yes, specify Cubar Yes 2X No ent's Usual Occupation of NoT use retired of NoT use retired of Structs.	If Under 24 Hrs. Hours Min. 8. Date (Mon) 0.5 / 31 spanic Origin? (Specify Yes n, Mexican, Puerto Rican, etc. Specify: attion furing most of working ion 18. Mother's Name (First, March 1985)	th, Day, Yea 0 6 / 1 9	Citizen of What Cou USA 14. Race - Ameri Black, White, Specify: o. Kind of Business/li extile anufactu den Surname)	10d. Inside City Limi 1 Yes 2 N ntry? ican Indian, a ctc. h
The stand of the management of	10a. State MD 10e. Street and Number 201 3100 Ellwood 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced 15. Decedent's Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last, Phillip J. Ha 19a. Informant's Name/Relationship (Patricia A Sim) 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Washington S Apt 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Education ade completed) College (1-4 or 5+) nna Sr (Type. Print) Daughter S	9 Ba. 700 5. 13. W ff 1 16a. Deced (Give & life. D COI	10f. Zip-Code 212.	spanic Origin? (Specify Yes n, Mexican, Puerto Rican, etc Specify: ation turing most of working LON 18. Mother's Name (First, M	or No-	Citizen of What Cou USA 14. Race - Ameri Black, White, Specify: Specify: CXTILE anufactu den Surname)	1 √ Yes 2 □ N intry? ican Indian, etc. à C.k industry
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pour inj	21. Signature of Funeral Service Licer	(fy) Cro	emetery, crem DWNSV	sition (Name of latory or other place Llle Cen	n	Cr	Location - City or Townsvill	le, MD
Q = 20	Phill All	all tetra	$\frac{22}{24}$	Name and Addres	^{ss of Facility} Philli Liver St Ba	p A T ltimo	Weatherf ore MD 2	ord FSP. 21213
and Medical xaminer Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, bearing to minimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence) b. Due to (or as a consequence) c. Due to (or as a consequence) d. Due to (or as a consequence)	ence of):	AKDIAL	INFARCT	CON		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)	/		23d. Date of deli	ivery Day Year
be d	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I. 23e	. Did tobacc	co use contribute to	
page 2	25. Was case referred to medical					Was an autopsy performed Yes 2	prior to death?	topsy findings availa completion of cause 2 No
iffer death. Director: After this in by the funeral d Briffication: To	exampler? 1 Yes 2 No 27. Mannor of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)		28c. Injury Work M 1 \(\)	#T: 4 Nursing Home 5 At 28d. Des Yes 2 No 28f. Local	Residence	injury occurred	
thin 24 hours the Funeral I mpletely filled		hysician: To the best of my know miner: On the basis of examinati and manner stated.						
To the comple	29b. Signature and title of certifier	CCMD		29c License	number - 660	29d.	Date signed (Month	, Day, Year) . 13,20
	30. Name and address of person who EDBERT 31. Date filed (Month, Day, Year)	completed cause of death (Item 450 32 Registrar's Signatu	_	Print)	600 North	Wolfe	St, Baltimo	ore, MD, 212

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 23, 2011 4:00 A M Junior Belford Horne Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 1418 Perryman Road Perryman . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. Sep. 22 Director 185-28-8675 Yrs 79 1932 Tennessee Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director notified 1 Tes 2 No Maryland Harford Perryman 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a 1418 Perryman Road 21130 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. ō ò 1 Never Married 2X Married filed within 72 hours after Maryland 21215-0036 If Yes, Give 1 Yes 2X No Specify: 'natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 6 Superintendent Pipe Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ pe John Henry Horne permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once. Mollie Mac Heaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda R. Horne / Wife 1418 Perryman Road, Perryman, Maryland 21130 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gdn 11-28-2011 Aberdeen, Maryland uperal Service Licensee Signature of 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) STROKE ARDIAC Medical Due to (or as a consequence of) Examiner ATHEROS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed CHOL PSTEPOL that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: Y/A 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) ed by the a Yes 2 No 9 Unknown 9 Unknown P.0. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, SEPTICEMIA 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown s been signated the Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performed certificate 1 Yes 2 No 2 🗷 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 \(\text{Nursing Home} \) 5 \(\overline{\text{V}} \) Residence 6 \(\text{Other (Specify)} \) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of nin 24 hours after death.

The Funeral Director: After appleted filled in by the funer 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F

complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Socod Anuvaa D5060532 11.23.11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANURAAG

DHMH 17 Rev 7/2009

State Registrar trar's Signature

WALNUT

LANE

ABERDEEN

mb 21001

800

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Vincent Hamby Jr. 12:10 PM November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 2311 Jerry's Road Street If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, 1 Apr. 18, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland . 1947 1 XM 2 □ F Months Director Apr. 219-44-6986 64 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🌁 No Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21154 3433 Grier Nursery Road USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married XYes 2 □ No ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Salesman Automobile Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alice Rebecca Hanson William Vincent Hamby Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda M. Hamby / Wife 3433 Grier Nursery Road, Street, MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn. 11-28-11 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral
50 W. Broadway. 21. Signa of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ara Itu Kemic Medical resulting in death) consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No 1 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 - Residence 6 Nother (Specify) Son's filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Residence 1 Natural 5 Pending work 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 05 48 41

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) ✔

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAHR

95HKAN

3/11

500 Upper Chesapeake Dr., Bel Air, MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 22, 2011 11:15 PM Hicks Elizabeth Poteet Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 1212 Whitaker Mill Road Joppa 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign **Funeral** 565-46-5946 1 □ M 2 🔀 F Months Days Maryland Director 80 Aug. Usual Residence of Decedent shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If ifew 272 is marked of other than "natural", or items 23a or 28a-f sho ury or orher traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21085 USA 1212 Whitaker Mill Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🙀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Wilmer Poteet Katherine (nmn) Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1210 Whitaker Mill Road, Joppa, Maryland 21085 Elizabeth Hicks / Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Dremation 3 Removal from State Hilltop Service Corp. 11-26-2011 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ carcino netastatic disease or condition Medical resulting in death) **Examiner** pertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery þ Completed

or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after death

Be မ Certificate: Medical

1 Yes 2 W No 9 Unknown		4 ☐ Pregnant at time of of 9 ☐ Unknown	death 5 C	ther ((specify)			Month	Day	Year
Part II. Other significant conditions	s contr	ributing to death but not res	sulting in the unde	erlyin	g cause given in Part I.	23e. Did tobad				e of death?
						24a. Was an autopsy performe	d?	prior to death?	completion	ings available n of cause of o
25. Was case referred to medical	T				26. Place of Death (Che	ck only one)				
examiner? 1 Yes 2 No	Hos	spital: 1 Inpatient 2	ER/Outpatient	з 🗆	DOA Other: 4 \(\sum \) Nursing H	lome Residence	e 6 🗆 (Other (Spe	ecify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat		28a. Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how	njury occ	curred		
3 Suicide 6 Could no 4 Homicide determine		28e. Place of Injury - At he building, etc. (Specify		facto	ory, office	28f. Location (Stree City or Town, S		ımber or R	ural Route N	Vumber,
29a, Certifier 1 Certifying P	hysici	an: To the best of my know	ledge, death occ	ured	at the time, date and place, a	and due to the cause	s) and ma	anner as s	tated.	

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ppa, MD 21085

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24 hours a Hospital

within 2 To the F

completed

(Check

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902 Averill R

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #195 tale of Maryland / Department of Health and Mental Hygiene amend #7 Per FH G922 12/06/17011 JH Death State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11 18 2011 00:05 AM M Joseph Edward Johnson, Jr Medical 4a. Facility Name (if not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Howard Gilchrist Hospice Columbia 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) (Month, Day, Year) Director 61 215-56-3037 1 X M 2 🗆 F 10/17/1950 Maryland ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and: If Item 27.5 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or orther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2🛣 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1815 Wilson Point Road U.S.A. 21220 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 IX Yes Z LING If Yes, Give Vietnam Year or Dates. Era 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Vinton Shafer Co. 12 Project Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Edward Johnson, Sr Dorothy Anna Stach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Burchap** permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Drive - Montgomery Village, MD <u>Meghan K. Homa (daughter)</u> Burchap Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗋 Burial 2 💢 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/22/2011 | Baltimore, Maryland ure of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ GASTRIC MUNTHS disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.D. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EMPHY SEMA 1 X Yes 2 No 3 Probably 4 Unknown CORONARY ARTURY DISEASE Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗷 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours To the Funeral Medical 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D64395 NOVEMBER 18,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEDAR LANE COLIRMBIA, MD 21044 DANIEUE DOGERMAN, MD 6336 31. Date filed (Month, Day, Year, 32. Registrar's Signature State NOV 3 0 2011 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Linnwood Jackson 3.50A 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore** Randalistown Seasons Hospice of Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth **Funeral** 1 M 2 D F Months (Month, Day, Year) Mar 2, 1950 Director 213-62-8899 61 Yrs. Usual Residence of Decedent 28a-f shov at 10b. County 10c. City, Town or Location Od. Inside City Limits the Medical Examiner must be notified 1 Yes 2 No Direct **Baltimore Baltimore City** MD 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 21230 U.S.A. 1004 Creek Street items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married "natural", or Maryland 21215-0036 1 Yes 2 No Specify: **Black** If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) l Hygiene. Campbell Realty Maintenance 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Mary Cooper Horace Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 2918 Byron Court Abingdon, MD 21009 Angela Cooper Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Nov 25, 2011 Brooklyn Park, Md. Cedar Hill Cemetery & 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature - Fun ral Service Lic Name and Address of Facility
 Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217
 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause or each line terval Between Onset and Death Immediate Cause (Final Physician/ Renal Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 the ass IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Yes be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Tother (Specify) Hospital 2 No Other: မ 1 Tyes 1 Inpatient 2 ER/Outpatient this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred s after death. Certificate: 28c. Injury at Natural 5 Pending work? 1 🔲 Yes 2 🗌 No the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

MV

DHMH 17 Rev 06-2011

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

N.S ROJAPAKSCIMID

MS RajapalneM.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Smith AV

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

00057465

5203

Biltimore

MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Vivian Alberta King-Moore 2011 November 10:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Patuxent River Health & Rehab.Ctr. Laurel Prince George Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) Director 323-26-1175 1 M 2 XF 96 Yrs. Oct.31,1915 Alabama Usual Residence of Deced 28a-f shov 10d. Inside City Limits items 23a or 28a-f sho her must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD 1 Yes 2 X No Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3505 Carriage Walk Lane 20724 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Black, White, etc 0 2 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 African If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 27 is marked other than "natural", traumatic event, the Medical Exa 3 Widowed 4 ☐ Divorced Completed American Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry عداله be filed with. خوا Hygiene. خو**r than "r** (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Medical permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other transcript Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert King Vela Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sana D. Sims/ Daughter 3505 Carriage Walk Lane, Laurel, MD 20724 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 27 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State West Arundel Crem. 2011 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01053 313 Talbott Ave, Laurel, MD 20707 Left 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheimer Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Directo for as a poinsection of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Exam and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buris Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death signed by the at d be detached for Yes 2 No 1 Yes 2 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hyperlipidemia 1 Yes 2 No 3 Probably 4 Nown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2★No 24a. Was an autopsy performed? page 2 s certificate 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1XX_{Natural} 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined

Il or Attending Physician: after death. Director: After this certific within 24 hours a the Hospital 0

31. Date filed (Month, Day, Year) State Registrar

Medical

29a. Certifier (Check

3

NOV 3 0

29b. Signature and title of confifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9055 Mitul Dave, MD,

Chevrolet Dr Ellicott City. Registrar's Signature

1 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Month, Dalv. Year)

11

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29d Date signed (

MD 21042

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Maryland		tificate of D			Reg. No.	2011	38	072
	Physicia		1. Decedent's Name (First, Middle, Last Elisabeth	•	sarsky			2. Date of Dea)11 Year	3. Time of 8:30	Death Рм
	Medic Examin		4a. Facility Name (if not institution, give	street and number)	Jan Jie	4b. City, Town, or				County of Death		
	Funeral		Charles Tov 5. Social Security Number 6. Se	7. Age (In vrs. la	st birthday)		sville	8. Date of Birl	:h	Baltimo 9. Birth	place (State o	r Foreign
	Director		216-34-9556 11 Usual Residence of Decedent	□ M 2 🗓 F 81	Yrs.	Months Days	Hours Min.	05 <u>Manth, D</u> a	930	Cour	rmany	
	show dat	호	10a. State 10b. County	10c. City	, Town or Loc					11	10d. Inside Cit	ty Limits
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho et than Medical Examiner must be notified at	Funeral I	709 Maiden Choice	e Lane, 2 Soutl	h		.228			en of What Coul		
	r death or item niner m	y Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	1-	 Race - Americ Black, White, 		
99	ural", c	ted by	3 Midowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1	☐ Yes 2xxxNo	Specify:		s	pecify: Wh	ite _	
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21	d withir tygiene ther th	Be Co		4		Bookeeper				anufactu	ıring	
lanc	l be filed fental Hyg rked oth tic event	70 B	17. Father's Name (First, Middle, Last) Tobias May				18. Mother's Nam Em	e (First, Middle, ilie Kn				
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty Henry K. Rose – 1			g Address (Street a. Golf View						.7
Baltimore,	le 1 and t of Heal If item 3 or other		20a. Method of Disposition 1 ☐ Burial 2xxCremation 3 ☐	20b. Pl Removal from State	emetery, cren	sition (Name of natory or other place	e) i	Date		cation - City or To		
Itim Tim	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signs us of Funeral Service Ligens) Atl		Crematory . Name and Addres		7-2011		n Burnie		ne at
Ba	permi Depar Impo any ir		Mark M.13	xonamen)	MM	P, Inc, 7	7250 Wash	Blvd,	E1kr			
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.		er the mode of dying	g, such as cardiac o	or respiratory ar	rest,		Approximat Interval Bet Onset and I	ween
	Physician/ Medical		disease or condition resulting in death)	a. Due to (or as a consequ	ence of):							
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_	cate be executed physician and the burial-transit	calE	resulting in death) Last	Due to (or as a consequ	ence of):							
8760	tificate ng phys	Medi	IF FEMALE:	d								
30x 68	v requires that the death certific been signed by the attending should be detached for use as	Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnat 1 Live Birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnance Other (specify)	у		2	3d. Date of deliv	-	Year
P.O. Box	at the d d by the letache	Phys	9 Unknown Part II. Other significant conditions of	9 Unknown	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did t	obacco us	se contribute to t	he cause of d	leath?
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COLC	law req nas bee e 2 shot	nplet						24a. Was	psy	24b. Were auto prior to co death?	opsy findings a ompletion of c	available cause of
E Be	ysician: The law is certificate has director, page 2:	e Cor	25. Was case referred to medical			26 Pla	ace of Death (Chec	1 \(\text{Yes}	ormed? 2 No	1 Yes	2 🗆 No	57
Vita	hysicia nis cert I direct	To Be	examiner? 1 ☐ Yes 2 【✔No	Hospital: 1 ☐ Inpatient 2 ☐		nt 3 🗆 DOA Othe	- A		dence 6	Other (Specif	y)	
n of	nding P ith. After t	cate:	27. Manner of Death 1	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work		28d. Describe l	how injury	occurred		
Division of Vital Records,	or Atter after dea Director in by the	Certificate:	3 Suicide 6 Could not b 4 Homicide determined			eet, factory, office		28f. Location (Number or Rura	al Route Numb	oer,
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exam	isician: To the best of my knowl iner: On the basis of examination se Practioner: To the best of my	and/or inves	tigation, in my opinio	on, death occurred a	it the time, date	and place,	and due to the ca	ause(s) and ma	anner stated.
	To the within 2 To the comple	2	29b. Signature and title of certifier	Khandt Ckry		29c. License		oo, and ddo to a	29d. Date	e signed (Month,		-
	121		30. Name and address of person who	completed cause of death (Item		Print)	0 11 1					
	Sta	te	31. Date filed (Month, Day, Year)	urkharet 32. Jegistrar's Signat					-			
DHI	Registr MH 17 Rev 7/2		NOV 3 0_20	32. Jegistrar's Signat	3. A	are						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2011 Joseph John Kudrna 2:22 A MNov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9205 Santa Rita Road Baltimore Nottingham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours **Director** 212-34-1482 1 🔀 M 2 🗆 F 75 Sept. 13,1936 Maryland Usual Residence of Decede or 28a-f show notified at with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Baltimore Nottingham 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? ritems 23a or ner must be n Funeral 9205 Santa Rita Road 21236 United States death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status "natural", or iten edical Examiner Black, White, etc. 1 Never Married 2 X Married by 1 Yes 2 No If Yes, Give Year or Dates. ! 54 ! 57 Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Divorced White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Lieutenant Fire Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important; If item 27 is marked any injury or other traumatic ev once. မ Joseph F. Kudrna Cecilia L. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Millicent Kudrna / Wife 9205 Santa Rita Rd., Nottingham, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory Inc. 11/28/2011 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending physical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s autopsy performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\triangle \text{ Other (Specify)} \) 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after deaun.

To the Funeral Director: After t Certificate: 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Meeta Gulati, 9649 Belair Rd., 2nd Floor, White Marsh, MD 21236 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 26 per verb., g921 11/30/2011 dhb
Certificate of Death
Reg. No. 38074 State
Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Nov. Physician/ Hubert 2:30 рм Lee 13 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5330 Dorsey Hall Drive Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Jan. Pay, 1926 Months Days Hours Min. 235-34-7908 1 👿 M 2 🗆 F Westy Virginia Director 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "notice." item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Howard Ellicott City 1 🗆 Yes 2 🗀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5330 Dorsey Hall Drive 21042 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

X Yes 2 No Black, White, etc.
White Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates WWII 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of warking life, DO NOT use retired),

Machinist Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Robert Lee Ruth Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Lee, Wife 5330 Dorsey Hall Drive, Ellicott City, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Roselawn Memorial 11/17/2011 Princeton, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Seaver Funeral Service, Inc. 21. Signature 1507 N. Walker St., Princeton, WV 24740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Atterosclerofic Cardiovarcalan Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ilatera Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner igned by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li retarded.

Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No 1 🗌 Yes Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Tourer (Specify) 2 000 မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D30641 Nevember 14 2011

Registrar
DHMH 17 Rev 7/2009

State

201-109 Back

32. Registrar's Signature

never neck Road Balhor MD 2/221

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramesh Sabapalin

NOV 30

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death November 18 2011 Physician/ 4:15 P M Sheila Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year, 578-70-4651 **Director** 61 Yrs Sept 7 1950 Washington, DC ms 23a or 28a-f show must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland rinent of Health and Mental Hygiene.

Sant: If item 27 is marked other than "natural", or items 23a or 28a-f show iury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State Director MD 1X Yes 2 No Capitol Heights Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20743 1214 Elfin Avenue IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married ☐ Yes 2 **X** No Yes, Give by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government Staff Assistant 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Beatrice Η. Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3312 Altair Lane, Upper Marlboro, Maryland 20774 Timothy Spencer/Son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of F
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State Harmony Cemetery 11/26/2011 Landover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road, Landover, Maryland 20785 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 shock, or hear failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Cancer Metastatic 0/01 Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death signed by the at Id be detached fo g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Shock , Respiratory Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a, Was an autopsy performed page 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 7 No 1 🔁 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending ours after death. eral Director: Aft filled in by the fur 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Funer completely fill 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 067635 Z8 2011 person who completed cause of death (Item 23a) (Type, Print) co bergorn 7503 Surratts Road Clinton, Maryland 20735 31. Date filed

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23 2011 **ERNEST** LONG JR. NOVEMBER 10:45 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 397 LENLOW COURT #F ARUNDEL ARUNDEL GLEN BURNIE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F Days Hours Months JUNE 20 1949 **Director** 578-68-9180 62 VIRGINIA Usual Residence of Decede show 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director 28a-f 1 X Yes 2 No MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 397 LENLOW COURT # F 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ò 1 Never Married 2 X Married ≥ Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: BLACK "natural" Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8TH DISABLED NONE other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ၉ ERNEST LONG SR. BERTHA POTTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau MARY LONG/WIFE 397 LENLOW COURT #F GLEN BURNIE, MARYLAND 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/30/2011 HARMONY CEMETERY LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J.B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Waphney 7474 LANDOVER ROAD HYATSSTVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. WITH LIVER & LUNG METASTALIC set and Death Immediate Cause (Final Ph sician/ HEPATOCELLULAR CARCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HEPATITIS C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events CONGESTIVE HEART FAILURE and -trans Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical or Attending Physician: The law requires that the death certificate be 68760 se as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy ò in the past 12 months? Day Month Year Pregnant at time of death Unknown ed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? 1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this nours after death. neral Director: After this if filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier eted 1 (Check pertifying Nurse Practioner: To the best of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the comple

31. Date filed (Month, Day, Year) State Registrar

29b. Signature

GURMEET S. SAWHNEY M.D. 352 HOSPITAL DRIVE SUITE 202 GLENBURNIE, MARYLAND 21061

Atteno

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

of certifier

29c. License number

D44973

NOVEMBER 29, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38077 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day 28 Perr Calvin Physician/ Calvin Month Year 201 awrence 9-11AM November Medical 4c. County of Death Facility Name (if not institution, City, Town, or Location of Death **Examiner** Baltimore 01 Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Min NC Director 1 X M 2 □ F 18 show 10a, State 10b. Count Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 28a-f Dak 1 Yes 2 No GWUNN o 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA items 23a Robin Hill 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No Iryes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done duning most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic event, the Mea College (1-4 or 5+) Elementary/Secondary (0-12) Cabin Service Ethorade alled mown Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Lawrence Maggie Human 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6219 Robin Hill Road GWINN Dak MD Ursula Lawrence 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Number 2 Cremation 3 Removal from State Sykeculle, MD 03/2011 4 ☐ Donation 5 ☐ Other (Specify) Errene Funeral Services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vauann (auel Randalls town MD 21133 Koad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in fail ire. List only one cause on each line. nterval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami and -trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? nemia 24a. Was an page 2 autopsy performed 2 No Yes 2 1 Yes Division of Vital funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ours after death, leral Director: Aff filled in by the fu 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Certifying Nurse Practitioner To the best of my knowledge, death-To the 29b. Signature and title of certifier November 28,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VOI Sinai Hospital State Registrar NOV 3 0 2011

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11.08808 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ MI_ Month Year 2257 M 540 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Medical Cent University of Maryland Baltimore Bultimore. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Korea 1**X**XM 2 □ F Months Hours Min **Director** 215-66-2425 80 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Sykesville Howard 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be r Funeral 907 High Stepper Trail 21784 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 12 should be filed within 72 hours after dea lith and Mental Hygiene. 27 is marked other than "natural", or iten r traumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2X XNo Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XX No Specify: Specify. 3 K Widowed 4 Divorced Completed Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Chun Kyong Lim Joochun Sok 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s permit. Page 1 and.
Department of Healt
Important if Item 27
any injury or other tra Benjamin B. Lim - son 907 High Stepper Trail, Sykesville, MD 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 Soham 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Subdural hemorrhage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDIUM EXAMINER Examiner urknown Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Day Pregnant at time of death 1 Yes 2 No 9 Unknown that the as been signed by a 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Respirations Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas page certificate 2 No Yes 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital funeral director. Be 26. Place of Death (Check only one) 1 Yes 2 □ No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of e Hospital or Attending Pi 24 hours after death. e Funeral Director: After the leted filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending Fall from standing unknown unknam 1 Yes 2 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office completed filled in by determined building, etc. (Specify) home 907 Highstepper Trail, 21784 Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 20f certifier Jacob Collan 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 010585184 NOV 22 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21201 22 South Green Street Treob Collen MD

Registrar

State

31. Date filed (Month, Day,

32. Resstrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Albert Lamar 5:45 9 M 2011 brember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat **Examiner Baltimore** Randallstown Season Hospice-Northwest Hospital Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 8 Date of Birth **Funeral** (Month, Day Year) Mar 2, 1927 Days Hours Min VA 1 M 2 D F 84 267-24-8453 Director 28a-f show ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director X 1 ☐ Yes 2 ☐ No **Baltimore** MD **Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21229 643 North Augusta Avenue death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. or i þ 1 Never Married 2 Married filed within 72 hours after al Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black Specify "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) **Construction Worker** Construction 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Hattie Mae Anderson John Franklin and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 227 South Loudon Avenue Baltimore, MD 21229 . Page 1 and 2 strength a Health a tant: If item 27 is JoAnn Lee 20a Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Timonium, Md. Dec 01, 2011 **Dulaney Valley Memorial** Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Signatu of Funeral Service Lice 23a. Part 1. Effer the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Approximate Interval Between End- Stage Dementia Onset and Death Immediate Cause (Final Fh, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Eller and rhying Cause (Disease or injury Examine Due to (or as a consequence of) as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be with 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicial. P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No 25. Was case referred to pedical **Division of Vital** 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Wother (Specify) 2 No Other: ဂ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Watural work? 5 Pending 2 🗆 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MskajapalneM.D 00057465 11/26/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultmore MD 21209 nov N. S. Ray aparese, M.D 2835 Smith AV 31. Date filed (Month, 32. Registrar's Signature State 30 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	,	Cei	rtificate c	of Deat	h		R	eg. No.	
Physicia		 Decedent's Name (First, Midd 							2. Date of Dea		3. Time of Death
ical Examin	ner	Harrison Alle								r 25, 2011	1410 hrs
		4a. Facility Name (if not institution		er)				ocation of De	ath	4c. County of Dea	th
		10219 Ridgeline Drive					gomery		la n. ((n)	Montgomery	idh lasa (Otata as
Funeral		5. Social Security Number		3	ast birthday)	Month	er 1 Year	If Under 24 Hours	Min	rth (MM/DD/YYYY) 9. E Fore	ign
Director		089-20-1236	1√ M 2 F	8	34 Yr				02/01/	1927 °	ountry) NJ
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036 thin 7 than fedica	힐		5+			Chiro	pract	tor		Healt	h Care
ed wi	Completed	17. Father's Name (First, Middle	, Last)				18	8.Mother's Na	ame (First, Middle,	Maiden Surname)	
21; be fill riked	a	Grant Lynn							Thiebaud		
MD 21215-0036 12 should be filed within 7 tht and Mental Hygiene. a 27 is marked other than unnafte event, the Medita	의	19a. Informant's Name/Relations				_				mber, City or Town, Sta	
MC s of the state		Margaret Lynn 20a. Method of Disposition	/ Wife	Lagi	LO21				, Montgor	nery Villag	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatite event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation	n 3 Removal from	State	crematory or c	other place))			1	
					tro Cr	emato	ry Ir	nc. 11	/28/2011	Baltimore,	Maryland
Balti permit. Departu Import		4 Donation 5 Other S 21. Signature of Funeral Service	Licensee Alyson	K Tay	lor 22.	Name and	Address	of Facility C	remation	Society of	Maryland
	4	23a. Part I. Enter the disease, or			29	9 Fre	deric	ck ka.	, Baltimo	ore, Maryia	nd 21228 Approximate Interval
Physician /Medical		failure. List only one cause		eu ille deali	i. Do not enter	the mode (or dynig, s	do i as caldie	ic or respiratory an	est, shoot, or fleat	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Neck Injury Due to (or as a co		-£\·						Deatt
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	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence o	of):						
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OX 687 ath certifi		23b. Was decedent pregnant in to past 12 months?	- Livo Bird	n t at time of de	- H	etal death		_Ectopic pre	gnancy	Month	Day Year
Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 Un			eath 5 [] C	other (Spec	cify)				
that the death certifulated by the attending detached for use as	된	Part II. Other significant condi			esulting in the	underlying	g cause giv	ven in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
Division of Vital Records, P.O. pital or Attending Physician: The law requires that th ours after cleath. Peral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deach	Ş	Atherosclerotic Card	iovascular Diseas	e					1 Ye	s 2 🗹 No 3 🗌 Pr	obably 4 Unknown
ds, requir	Completed	Skin Cancer			-				24a. Was		autopsy findings available
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of V	의	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of	Iniury	28b. Time of		28c. Injury		28d. Describe	how injury occurred	
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ital o	erti	- C Suicide		Single Fan	nily Home				or Town, 10219 Ridge	State) line Drive, Montgomo	ery Village, MD
Hosp 24 ho. Fune stely fi		29a. Certifier 1 Certifying P	hysician: To the best o	f my knowled	lge, death occ	urred at the	time, date	e and place,	and due to the cau	se(s) and manner as st	ated.
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Exa	miner: On the basis of e	examination a	and/or investig	ation, in my	y opinion, (death occurre	ed at the time, date	and place, and due to	the cause(s)
F 3 F 3	ž	29b. Signature and title of certifi	er // // /			290	c. License			29d. Date signed (N	
		1) N	11/1	-			O.C.M	1.E.		November 26,	2011
vě`	İ	30. Name and address of person	•		000144	D-12	<u> </u>		MD 04000		
		Jack Titus MD. De	outy Chief Medica			Baltimo	re Stree	et, Baltimo	ore, MD 21223		
Sta	ate	31. Date filed (MMI) Day (e.f.)	2011 PReg	trar's Signat	35 May						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ IC CLEOD 15 Month P イノビ ZOU Medical give street and number) Examiner acility Name (if not institution. Town, or Location of Death 4c. County of Death USPITIAL -INORE **Funeral** . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours **Director** ms 23a or 28a-f show must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b County Funeral Director 10d. Inside City Limits 1 Yes 2 No or 10e. Street and Num 10f, Zip Code 10g. Citizen of What Country? 3708 21208 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) Was Decedent Ever Ju U.S. traumatic event, the Medical Examiner Armed Forces 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 Yes 2 No 1 ☐ Yes 2 ☐ No Specify If Yes, Give 3 ₩Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industri (Specify only high st grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Tather's Name (First, Middle, Last, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition Place of Disposition (Name of 20c. Location permit. Page 1 Department of I Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Name and Address 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and treath TA STATIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the IE EEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death Other (specify) Month Day Yes 2 No 9 Unknown 9 Unknown Records, P.O. by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen . Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy performe death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Hospital မှ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 _ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature. erson who completed cause of death (Item 23a) (Type, Print) (of

State Registrar 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Novemb Medical give street and num Eacility Name (if not institution, Examiner 4b. City. Town, or Location of Death 4c. County of Death Himore ontor . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 96 Days 1 M 2 D F Months Hours 0984 Country) Director MD Usual Residence of Decedent or 28a-f show 10b. County 10a. State within 72 hours after death with the Maryland by Funeral Director 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at ØYes, 2 □ No to ma 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Blac "natural", Specify: Completed 3 Nidowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) .ntorcement Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) 18, should be file hand Mental F and Mental မ other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 620 Juandian Baltimore. 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State .Date altimore 12/1/2011 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Lic feig 0.60 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respectively. shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final set and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any law in grant cause. Enter Underlying Be Completed by Physician/Medical Examiner Due to or as a consquence of Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No the 9 Unknown q 🗌 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be Division of Vital Records, 1 🗌 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 힏 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 🗆 Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 - Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier only one 29b. Signature, and title of certifie 29d. Date signed (Month 28 201 death (Item 23a) (Type, Print) 30. Name and address of person who comp State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 38083 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death November 11, 2011 Physician/ 7:48 Paul Ward Mumford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown 417 Indiana Avenue If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 577-24-1178 Aug 25, 1924 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 X No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 417 Indiana Avenue 21740 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. à 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. white Specify: 3 Widowed 4 Divorced 43-46 Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the visual information specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) And Personal Page 1 and 2 she.
And of Health and Me.
Them 27 is marked to traumatic ever and Mental F is marked of George Carl Mumford Elsie Wauneda Hundley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Getty Mumford/spouse 417 Indiana Avenue Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature of Suneral Service State MANAGE ON Board 655 W. Baltimore Street Baltimore, MD 21201 Leter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ DIASTIC Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by trial Fibrilla tion 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed partensiva Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 X To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 Ho Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No. Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

3 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

68760

Division of Vital Records,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D38471

22911 Jeffarson Blud Smiths bury MD

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 4 Physician/ Month 2011 5:30 November MOHAMMED Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Towson Greater Baltimore Medical Ctr. 5. Social Security Number If Under Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Min. 1 🗆 M 2 🛛 F Yrs Director infant Maryland /04/2011 0 Usual Residence of Decedent LP₁ iral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ☐ Yes 2 ☑ No RANDALLSTOWN BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9116 SAMOSET ROAD death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 0 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify Black Specify: "natural" 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NA MA æ permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is mediany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ABDULRAHMA MOHAMMED FATIMAH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21204
Raltimore. MD 21204 19a. Informant's Name/Relationship (Type, Print) Greater Baltimore Medical Ctr 6701 N. Charles Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 25 th Lend Address of Frysiit Board 655 W. Baltimore Street Vrector of Funeral Service Licenses ade Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Extreme Prematur disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) and Il-transit Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) been signed by the atte in the past 12 months? Month Day Year 2 🔀 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed? 2 No 1 🗌 Yes Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D51876 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #311, Towson, Maryland Hsiao-Hui Charles 31. Date filed (Month, Day, Year) NOV 3 0 State

Registrar

barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8 November **Physician** 2011 1:04A M Baby Girl Mohammed Twin B /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Year | If Under <u>Baltimore</u> 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 1 M 2 DF Months Days Hours Min. 50 Director infant Usual Residence of Decedent ,08,2011 MD 10a State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a death 1 Funeral <u>9116 Samoset Rd.</u> 21133 <u>USA</u> 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc. hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No \$ 3 ☐ Widowed 4 ☐ Divorced Specify: Pages 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", ury or other traumatic event, the Medical Exal Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NA NA NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Abdulrahma, Mohammed Fatimah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greater Baltimore Medical Ctr 6701 N. Charles Street Baltimore, MD 21204 of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of F Important: If ite any Injury or ot once. 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) In State Funeral Service I State MANUSMY Board 655 W. Baltimore Street Director an Baltimore, MD 21201 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** XTREME PREMATURIT /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) cate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □ Yes 1 ☐ Yes 2 🗆 No After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending To the Hospital or Attendil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 3 0 2011

Marke

29c. License number

DO051876

29d. Date signed (Month, Day, Year)

and manner stated

Hsiao-Hui 6565N. Charles St #311 Towson, MD 21204

22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year onald Metzler 0012 2011 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Mercy Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 218-28-960 1 🗙 M 2 🗆 F Hours (Month, Day, Year, 80 Director Maryland 04104131 Usual Residence of Deceden show. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1222 Riverside Avenue 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates **'**51**-**55 1 ☐ Yes 2 🕅 No Specify 3 Widowed 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Milburn Metzler Mildred Mae Stickles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1222 Riverside AVenue Baltimore, MD Elizabeth Metzler/spouse 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 X Donation 5 ☐ Other (Specify) State and Address of Board 655 W. Baltimore Street onn MDPart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death HY Poxia disease or condition Medical resulting in death) Examiner chronic obstructive pulmonary disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a conseq requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical † ∠ ر المراقق المراق 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ Unknown detached 9 Unknown ģ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page perform death? Hospital or Attending Physician; The After this certificate Yes 2 No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) Hospital 2 🗆 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending nours after death neral Director: A filled in by the fi 1 Yes 2 No death Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) Resident Physicia 11, 17, 2011 **RES 0000** 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Knowah 22 S. Greene St. Baltimore MD, 21201 31. Date filed (Month. Day: Year) State NOA 3 U Registrar

4a. Facility Name (if 5843 Di 5. Social Security Ni 213-46-19 Usual Residence of 10a. State MD 10e. Street and Num 5843 Dig 11. Marital Status 1 Never Marr 3 Widowed (Spe Elementary/Second 17. Father's Name (if Charle 19a. Informant's Na Kathlee 20a. Method of Disg 1 Burial 2 4 K Donation	Maxwell not institution, give ggers La umber 6.5 914 10b. County Howar nber ggers La ided 2 🖫 Married 4 🗆 Divorced 15. Decedent's Ecify only highest gi sindary (0-12) 2 First, Middle, Last) s Maxwel. ume/Relationship (in E. McE	McElroy a street and number) ane Sex Ame 12. Was Decedent I Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates. Education reade completed) College (1-4 or 5	No 164-93	wn or Locati E1kr: 13. Was If Ye 1 Give kine.	Elkric If Under 1 Year Months Days ion idge 10f. Zip Code 21 s Decedent of Hiese, specify Cuba Yes 2 X No it's Usual Occup.	Location of Death ge If Under 24 Hrs. Hours Min. 075 spanic Origin? (Spen, Mexican, Puerto	2. Date of Dea Month Per Sept 26	4c. County Howa Year) 10g. Citizen of USA	of Death ard 9. Birt Con Man	thplace (State or untry) cyland 10d. Inside City 1 Yes :	Limits
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Kathlee 20a. Method of Disp 1 □ Burial 2 4 🗓 Donation	n E. McE					18. Mother's Name Frances	(First, Middle, I			-	
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21. Signature Fu	Cremation 3 5 Other (Spec	Removal from State		of Dispositi tery, cremate	ion (Name of ory or other plac	e)	Date	20c. Location	- City or	Town, State	
100	neral Se vice Licen	Joy Dir	ector		lame and Addres ite Anat timore,	ömy Board MD 2120	655 W.	Baltim	ore	Street	
shock, or hear Immediate Cause (rt failure. List only o Final	nplications that caused one cause on each line	d the death. Do	o not enter th	he mode of dyin	g, such as cardiac c	r respiratory arre	est,		Approximate Interval Betw Onset and De	
disease or condition resulting in death)	n C	a. Due to (or as	aconsequence		`					2	100
Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate rlying	b. Due to (or as	1	90 m2 e of):	.					Je	<u>u</u>
		C. Due to (or as	a consequence	e of):							
IE EENAAL E.		- d									
23b. Was decedent in the past 12 1 ☐ Yes 2 ☐	months? Xo No	1 Live Birth	2 Fetal dea			у					ar
		contributing to death b	out not resulting	g in the unde	lerlying cause giv	ven in Part I.					
						<u> </u>		,			
							autop perfor	med?	prior to o death?	completion of ca	use of
examiner?		Hospital:			Othe	er:					
(_	28a. Date of inju	ıry 28b	. Time of	3 🗆 DOA	4 L Nursing Ho				cify)	
1 Natural 2 Accident		n	y, Year)	injury		?					
3 ☐ Suicide 4 ☐ Homicide		28e. Place of Inju		farm, street,	, factory, office				er or Ru	ral Route Numbe	r,
(Check 2	☐ Medical Exam	niner: On the basis of e	examination and se best of my kn	d/or investiga	ation, in my opinio	on, death occurred at	the time, date ar	nd place, and du	e to the o	cause(s) and man	ner stated.
29b. Signature and	title of certifier	he as	MI	2	29c. License	3 8 76 3);	29d. Date signe	d (Month	h, Day, Year)	
30. Name and address	ess of person who	completed cause of cederick Rd	leath (Item 23a	a) (Type, Prin	g Shar	m J. 1	Me Cor	macle 1	10		
31. Date filed (Mont	h, Day, Year)	32. Registr	ar's Signature	-7.							
	cause. Enter Under Cause (Disease or that initiated event resulting in death) I IF FEMALE: 23b. Was decedent in the past 12: 1	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death the series of person who completed cause of the conditions. To the basis of conditions on the basis of conditions. To the basis of conditions. The basis of conditions of the basis of conditions. The basis of conditions. The basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions of the basis of conditions. The basis of conditions of the basis of conditions of the basis of conditions. The basis of conditions of the basis of condi	Cause (Disease or injury that initiated events resulting in death) Last C.	Cause (Disease or injury that initiated events resulting in death) Last C.	Cause. Disease or injury that initiated events resulting in death) Last FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given the properties of injury 28c. Injury	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d. FEMALE:	Cause, (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d. Due to (or as a consequence of):	Cause, Entered underlying Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d. Due to (or as a consequence of): adverting the properties of the part	Cause. [Diseas or injury that inhibated events resulting in death) Last C. Due to (or as a consequence of): d. FEMALE: 23b. Was decedent pregnant in the past 12 months? Live Birth 2 Fetal death 3

Registrar DHMH 17 Rev 06-2011 For State Registrar

10a. State

5. Social Security Number

217-26-2988

1. Decedent's Name (First, Middle, Last)

Elizabeth Caslin Moore 4a. Facility Name (if not institution, give street and number)

1 🗆 M 2 🏋 F

St. Joseph Hospital

10b. County

and sho	te a	5	10a. State	10b. County		10c. City	y, Town c	r Locati	ion						10d. Inside City Limits
Aaryl 8a-f	tified	Je Cl	MD	Baltimor	ce	To	owson	n							1 🗌 Yes 2💢 No
the A	e no	፭ቨ	10e. Street and Nun	nber					10f. Zip Code				10g. C	Citizen of What C	Country?
with 23a	ustb	Funeral Director	205 E.	Joppa Rd.	#2205				212	86				USA	
eath	er m	딆	11. Marital Status		12. Was Decedent E	ver in U.S	S.	13. Was	Decedent of I	lispanic O	rigin? (Speci	fy Yes or No	-	14. Race - Am	erican Indian,
fer d	min	ठ्व	1 Never Marri	ied 2 🛚 Married	Armed Forces?	No	i		es, specify Cub			can, etc.)		Black, Wh	
urs a	Ex	털	3 Widowed	4 Divorced	If Yes, Give Year or Dates.			1 🗆	Yes 2 X No	o Specin	y:			Specify:	white
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and Heal	othe		20a. Method of Disp			20b. Pi	lace of D)ispositi	on (Name of	:				Location - City of	
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nit. P artme	injur	H	21. Signature of Fur		**	Memo	orıa		ardens ame and Addre			1		Timoniu	n, MD
permit. Page 1 and 2 Department of Healtl Important: If item 2	any ir		Micha	0000	agle	•		Le	emmon F	unera	Home	e of D	ulaı	ney Val	ley, Inc. 93
		\neg	23a. Part Timer ti	he disease, or com	plications that caused	the death	n. Do not							TID ZIO	Approximate
Physic	ion/		shock, or hear Immediate Cause (I		ne cause on each line										Interval Between Onset and Death
Mec			disease or condition resulting in death)	n	a. Due to (or as a	CONSEGU	ence off								>3 dec 45
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deat he at	od fo	Sici	1 Yes 2 1 9 Unknown	No.	4 Pregnant at 9 Unknown				ther (specify)					Month	Day Year
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The	bage	S	-									1 🗆 Yes	ormed?	death?	es 2 No
ician	ector,	20	25. Was case referre examiner?	_ /	Hospital:						ath (Check o	nly one)			
Physi this c	al dir	2	1 ☐ Yes 2 € 27. Manner of Death	No	1 Inpatie					4 L N				6 Other (Spe	cify)
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate	the i	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not be		n/ - At hor	me form			Yes 2		f 14: /	04		
l or A after Direct	년 전	S	4 Homicide	determined	building, etc.			, street,	lactory, office		20	City or Tou			ural Route Number,
spita lours neral	illec	ا ا	29a. Certifier 1	Certifying Phys	sician: To the best of r	nv knowle	edge de	ath occi	ired at the time	date and	t place and o	due to the ca	use(s) a	and manner as s	tated
e Ho 124 h e Fur	leted	Medical	(Check 2	Medical Exami	ner: On the basis of ex se Practioner: To the b	amination	and/or ir	rvestigat	tion, in my opini	on, death of	occurred at the	e time, date a	and place	e, and due to the	cause(s) and manner state
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4		1	30. Name and addre	ess of person who o	ompleted cause of de	ath (Item:	23a) (Typ	oe, Print						100	
81				Bangoria,					pa Rd.	Suite	e 1, B	alto,	MD	21234	
1	State		31. Date filed (Month		2. Registra				,						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

7. Age (In yrs. last birthday)

Yrs.

86

4b. City, Town, or Location of Death

Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 2. Date of Death

8. Date of Birth (Month, Day, Year) Aug. 6, 1925

2^{Bay}

2**0**11

4c. County of Death **Baltimore**

12:30 PM

9. Birthplace (State or Foreign

1 Yes 2X No

Maryland

Nov.

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

amend #9 Per FH G921 11/30/2011 JH

State of Maryland / Department of Health and Mental Hygiene

1 - State AMEND PI LINE B-C, 25,27,28A-F, PER ME G930 8/8/12 TRT

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Minner Physician/ Month Da 21278 M harles 7011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** tookins Johns Baltimore If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Ne Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) 201-28-0506 **Director** 1 XM 2 □ F 75 11/12/1936 Usual Residence of Decedent 28a-f show at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 Yes 2 No MS Ocean Springs Jackson 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? ritems 23a c with t Funeral 3200 NW Beachview Drive USA 39564 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Force Black, White, etc. ò 1 Never Married 2 Married b Yes 2X XNC Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: "natural", Specify: Completed 3 Wildowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service 12 Manager Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ဂ Charles Minner Ruth Jarrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Spirk Daughter Gettysburg Ct Medford 305 NJ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 11/26/201 Glen Burnie MD 4 Donation 5 Other (Specify) Atlantic Crematory Constantino Funeral Home Signature of Fun in Name and Address of Facility any in W. White Horse Pike, Berlin, NJ 08009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. ician MEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SPINAL INJURY (BURST FRACTURE OF 12TH THORACIC VERTEBRA) equentially list do aditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMIN and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) fo in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the a should be detached Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law page 2 certificate has autopsy performed? Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 24 hours after death.
Funeral Director: After this etely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at SUBJECT DRIVER OF CAR LEFT ROADWAY & STRUCK A DITCH Natural 2X Accident 5 Pending 8/25/2011 4:29 P 1 Yes 2 **X**No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) HWY 90 & BAINVILLE BLVD • OCEAN SPRINGS • MS Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined ROADWAY Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifi 29c. License number NOVEMBER 23,7011 -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North wolfe St. Balitimore Maryland 21287 10 V 600 Dhathan Kukin

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) NOV 3 0

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Erma A. Hankins Maddox NOVEMBE Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL AGNES BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 M 2 XF (Month, Day, Year) Jan 3, 1919 Country) 219-12-8150 PA. 92 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD **Baltimore Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A. 4202 Maine Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗷 No þ 1 Never Married 2 Married Black, White, etc. 1 and 2 should be filed within 72 hours after if Health and Mental Hygiene.
item 27 is marked other than "natural", or 3altimore, Maryland 21215-0036 ☐ Yes 2 No Specify: Black If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lafayette Alexander Lillian Jessup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1141 Rock Elm Drive Auburn, GA 30011 Aubrey V. Alexander 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State Dec 02, 2011 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 0 23a. Part 1. Enter the plisease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart reliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASPIRATION PNEUMONIA disease or condition 10 DAYS Medical resulting in death) Due to (or as a consequence of) **Examiner** FROM 11 12/11 11 DAYS EXTENSION 5 squer tiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) iician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of DEMENTIA 24a. Was an autopsy death? 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be examiner? 2 No မ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MARUPUDI, MD SINDHUJA 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 4

Registrar

State

Sindhuja Marupudi

31. Date filed (Month, Day, Year)

ADOUG

C

Agnes HOspital, Baltimore,

Md.

St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5 Month Year Physician 09:17 AM DORIS 2011 NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year)
AUG. 21, 1922 MARYLAND If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 💢 F 215-14-4579 89 Director Usual Residence of Decedent death with the Maryland Show 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 □ No Director MD N/A 28a-f BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? č pe 6424 E. PRATT STREET APT. 202 21224 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: Yes, Give þ Specify: WHITE 3 Widowed 4 Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) the Me Elementary/Secondary (0-12) College (1-4 or 5+) **SEAMSTRESS** CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental H 27 is marked of traumatic ever GEORGE DOERFLER **EVA** STRICKROTH ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a CONSTANCE DRIGGERS/DAUGHTER 16 WOODMANS COURT, BALTIMORE, MD item 27 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Department o Important: If any Injury or once. = 0 MOST HOLY REDEEMER 11/29/11 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funer Conce Licensee 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
700 S. CONKLING STREET, BALTO., MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) psis **Physician** Je 7 day /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any label in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the att 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be do þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident the rector. 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 RES-000

Registrar DHMH 17 Rev 1/2001

11595

State

NOVEMBER 25 201

4940 Eastern Avenue, Baltimore, MD, 21224

AARON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHUENEMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Movemb Moore Physician/ 3:41 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 5. Social Security Number 533-21-0406 Hours *Nonth, Day, Year)* **10/17/9**0 Director 1**XX**M 2 □ F 21 Washington shov 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f Virginia James City Williamsburg XX Yes 2 No 10e. Street and Numbe 10f. Zip Code 5 10a. Citizen of What Country? ms 23a or must be Funeral 162 Marywood 23185 USA ural", or items ! Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2**XX**No If Yes, Give Baltimore, Maryland 21215-0036 Black/White 1 Yes 2 XXo Specify. "natural" Completed 3 Widowed 4 Divorced Specify Year or Dates of health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical of 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) 12 College (1-4 or 5+) Retail Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John J. Moore Rhonda J. Mayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Moore/Mother 162 Marywood Drive, Williamsburg Virginia 23185 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Superior Cremation Services 20c. Location - City or Town, State 0 1 Burial 2 Cremation 3 Removal from State Department (Important: If any injury or once. Merrill, MI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ser 22 Name and Address of Facility Charles L. Stevens Funeral Home, 1501 E. Fort Avenue Baltimore MD rice Licensee Victor Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical ue o (or as a consequence of): **Examiner** tungemia Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to or as a consequence of): Examir signed by the attending physician and id be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed Hospital or Attending Physician: The l 24 hours after death. 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗷 No Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marner as stated. only one) 29b. Signature and title of certifier 29c. License number - 000

Registrar

DHMH 17 Rev 06-2011

State

000

Wolfe Street Baltingre, MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 7:00 2011 Ам Physician/ Jerrelean Murray Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Towson Manor Care Ruxton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Georgia **Funeral** (Month, Day, Days Hours 1 □ M 2 🖫 F 1942 69 **Director** 212-44-9355 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Gwynn Oak Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21207 2121 Windsor Garden Lane, Apt. B221 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces <u>ک</u> 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify **Black** Completed 3 Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Unknown Unknown Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) မ Mariah Jones Ralph Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1593 Foxhall Road, Blacklick, Ohio 43004 William B. Flint/Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 11/28/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Entertie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. as a consequence of cause. Enter Underlying Exami use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day in the past 12 months?

1 Yes 2 No ō Pregnant at time of death the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 has 2 No 1 1 Yes this certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) ဂ္ 27. Man er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the t Suicide
Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signati completed cause of death (Item 23a) (Type, Print) altram Wood Ol State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38094 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Delores McCord 11 2011 8:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Baltimore Towson 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 212-46-2693 63 1 M 2 XF Maryland 03 18 1948 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland N/A Baltimore City 1X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 3732 Elmora Avenue the Medical Examiner must 21213 United States or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Crowell Delores White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Shawn McCord-SON 3732 Elmora Avenue, Baltimore, MD 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 5 Other (Specify) 11-26-2011 Baltimore Maryland Crematory INC Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimore MD 21228 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each live. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) MUE Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Hospital Z No ျ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 To the F 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) enous R125808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Stc 4105, Butimore 1070/N. Charles St. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38095 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 28, 2011 Physician/ 6:40 P M Ray Maines Herbert Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Harford Darlington 3816 Conowingo Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Mar. 21, 9. Birthplace (State or Foreign Age (In yrs, last birthday **Funeral** Days 1 M 2 □ F Months Hours Virginia 89 221-14-3098 Mar. Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director 1 🗆 Yes 2 🔀 No Darlington <u>Maryland</u> Harford 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21034 3816 Conowingo Road hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify. th and Mental Hygiene.
27 is marked other than "natural", traumatic event, the Medical Exar White Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Seconday (0-12) College (1-4 or 5+) Residential Painter Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Minnie Blanche Bebber permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Charles Franklin Maines Sr. . 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2124 Carrs Mill Road, Fallston, MD 21047 Shirley Linkous / Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Welcome Home Bapt. Cem. 12-2-2011 Bel Air, Maryland McComas Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 23a. Part 1. Enter the disease, or complications Onset and Death Immediate Cause (Final disease or condition Physician Meningo encephalitis Medical resulting in death) Due to (or as a correquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and-trar Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 Pregnant
9 Unknown the P.0. þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to þ 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗆 No 1 Tes certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one, Be examiner? Hospital: Other: 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) ဂ္ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No ∠Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1.X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

State

only one 29b. Signature and title

31. Date filed (Mo

30. Name and address of person who completed cause of death (Item 23a) (Type,

M

Registrar's Signat

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician/ 25:14 Dane Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (if not insti ution, give street and number) 4b. City, Examiner Beltimore NIVE SIL Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** Hours **Director** 1 □ M 2 🔀 F 213-36-8260 Yrs 85 July 4, 1926 Pennsylvania Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21014 USA 103 F Donzen Drive death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Telephone al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Office Administrator Communications other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H ည Anna Mildred Nicodemus Elmer David Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other traus 3151 Rocks Chrome Hill Road, Jarrettsville, Maryland Mary L. Jones / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 11/26/2011 Hydes, Maryland 4 ☐ Donation 5 ☐ Other (Specify) John Cemetery 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronery disease or condition Medical resulting in death) Due to (or as a consequite Examiner 000 Sequentially list conditions, if an leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last y physician and Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No for Month Year Other (specify) Pregnant at time of death signed by the at 1 ☐ Yes ∠ □ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 7 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Tes I or Attending Physician: after death.

Director: After this certifications filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 🗹 No ျှ M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Ma ver of Death 28b. Time of 28c. Injury at 28d Describe how injury occurred Certificate: iniury work?
1 Yes 2 No Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Confifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D67225 11. 22-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

MOUTO

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month November 8:30 AM Physician/ Year 2011 Nussbaum 27 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number 7. Age (In yrs. last birthday) 83 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 2 K Hours Mar Year 928 128-20-3758 New York **Director** Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Baltimore Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? be Funeral ral", or items 23a Examiner must b 2901 Fallstaff Road Apt. 404 21209 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 No Specify: White "natural" 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Medone. College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Aaron Cohen Mary Bloom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Bark /Daughter 2019 Jolly Road Baltimore, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov 27 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 2011 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a con a uence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? detached for Pregnant at time of death Month 5 Other (specify) Day Year Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be Records, 1 🗌 Yes 2 No. 🗸 🗌 Probably 4 🔲 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performe 2 🗌 No 1 📮 Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 1 100 1 🗌 Ye မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this of er of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending Division 1 Yes 2 No after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 🗌 Homicide determined building, etc. (Specify) 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit 29c. License number

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 533 PM Medical Name (if not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner altmare If Under 24 Hrs Hours Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) **Director** 216-22-0336 1 🕅 M 2 🗆 F 85 Jan 29, 1926 Maryland Usual Residence of Decede 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location notified at Director 1 Yes 2 X No MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ö er than "natural", or items 23a or the Medical Examiner must be r Funeral 801 Brooklyn Bridge Road 20707 U.S.A. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces?

1 X Yes 2 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1942-46 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry te filed with... Elementary/Secondary (0-12) College (1-4 or 5+) 12 Flooring Mechanic Flooring d 2 should be filed with alth and Mental Hygien 27 is marked other the Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ဂ Katie Beall Franklin Benjamin Owens traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any injury or any injur 801 Brooklyn Bridge Rd., Laurel, Maryland 20707 M. Olga Owens / spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Emmanuel UMC Cem. Nov 30, 11 Scaggsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave., Laurel, Ma 21. Signatur M00773 Maryland 20707-4389 23a. Part 1. Enter nevisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician DINTE disease or condition Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying s a consequence of) Examir burial-transit Cause (Disease or injury that initiated events resulting in death) Last DX 60 and Due to (or as a donsequence of) physiciar Physician/Medical certificate be Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ P in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death 1 Yes 2 L 9 Unknown be detached the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should been: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X No has 1 🗌 Yes 2 🗌 No Director: After this certificate or Attending Physician: director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes _2 No ER/Outpatient 3 DOA 1 Nnpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

To the Hospital or within 24 hours at To the Funeral D Medical (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Dertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nd title of certifie 29d. Date signed (Month. Dav. Year) 29b. Signatu 783888 VOV ho completed cause of death (Item 23a) (Type, Print) 101 30. Name and address of pers rune Street Baltemar Mayland W. 132 22 Dracu 31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar 29a, Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** November 28 2011 MARY HELEN PARSONS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Quare Hospita If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Days Hours Year Months Min Yrs 20 SEPT 1931 Director 80 NORTH CAROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show event, the Medical Examiner must be notified at Director 1 ∏Yes 2 No 28a-f MARYLAND BALTIMORE **ESSEX** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō items 23a 1315 GOODWOOD AVENUE U.S.A 21221 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status $\mathcal{P}_{\mathcal{A}\mathcal{CSONS}}$, $\mathcal{M}_{\mathcal{A}\mathcal{L}}$ Baltimore, Maryland 21215-0036 1 Never Married 2 Married "natural", or 1 ☐ Yes XX No þ XX Widowed 4 □ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) BALTO CITY SCHOOL is merked other than Elementary/Secondary (0-12) College (1-4or 5+) SYSTEM 12yrs Cafeteria Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM BROWN LAURA BROWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Depertment of Health a
Importent: If Item 27 is
any In]ury or other tra. 3016 Lewis Lane, Havre de Grace, Md., 21078 Thomas Parsons, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILLS MEMORIAL 12-02-11 MIDDLE RIVER, MARYLAND Name and Address of Facility
ILLIAM C BROWN COMM FUNERAL HOME21 S PHILADELPHIA BLVD, ABERDEEN, 21. Signature of Funeral Service Licensee 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Incarcerated /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed -trar Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a Ö 9 Unknown 9 Unknown ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probabiy 4 ☑ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has bage 2 s performed?/ Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗹 Inpatient ٩ 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? Division Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) RES0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 1/2001 Source Drive Baltimore, MD. 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:18 P M R. Michael ovember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 521 South Marlyn Avenue Essex Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Director 212-50-6027 1 X M 2 □ F 63 July 7,1948 Maryland Usual Residence of Deceden 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Baltimore 1 Yes 2 Xio Essex 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 521 South Marlyn Avenue 21221 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. o. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" Completed 3 Widowed 4 Divorced Yes, Give Specify: White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 2 years 12 years Secretary Portable Toilets Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Holden Ruth Donnelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Pittman 27 wife 521 South Marlyn Avenue, Essex, Maryland item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. December 1 XBurial 2 Cremation 3 Removal from State Cardens of Faith Cemetery Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 1, 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. hitlory 23a. Part 1. Enter the disease, a complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. Lim only one cause on each line Immediate Cause (Final Physician Stomach disease or condition resulting in death) Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Prennant at time of death 5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 🗆 No 1 Tes 25. Was case referred to medical Ba B 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify, this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practition or Turk bound of my browning of all occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practition or Turk bound of the cause of the c 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) MS Eyapahi(M.1) 00057465 11/30/11

Registrar

DHMH 17 Rev 06-2011

Smin AV 1 703

2835

Registrar's Signature

Baltimore MO 21709

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RajagaKH, MID

N-5

NOV 30

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No Decedent's Name (First, Middle, 2. Date of Death Physician/ Month Day 1148 M NOV Medical 4a. Facility Name (if not institution, give street and number **Examiner** Town, or Location of Death 4c. County of Death Markland of Merlical Baltimare University Social Security Number 6 Sex 7 Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 12-24-1960 Hours 577-90-0570 50 Wash DC Director 1 XM 2 □ F 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10b Count 10c. City, Town or Location must be notified at Director Washington DC 1 🗆 Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4931 North Capitol St. NE #21 USA Funeral 20011 23a "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian, Black, White, etc. þ 1X Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Stocker Private 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Banks Pratt Doris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Doris Butts/Mother 1720 Savannah St. SE #202 Wash. DC 20003 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Riverdale Park Crem. 12-1-2011 Riverdale, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Ronald Taylor II FH Kond 10583 Middleport Ln. White Plains, MD 20695 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): physician Physician/Medical death certificate be of Vital Records, P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death detached the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à should be 1 Tyes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 2 No. Hospital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural iniurv 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident
Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 1527 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GROVE ADVENTISE ROCKVILLE MONTGOMER Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 218-96-6729 Director 1 M 2 🗆 F 126/1926 28a-f show Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MONTGOMER ALHERS 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral BROOKE 99 20 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: 1951AN If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ERSONAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ၉ look SUK KODON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) z 499 SAYBROOKE VIEW DR-GATHERSHURG. 503 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 130/2011 NOR CEM 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service kicensee 1022 EGUIL FOUND, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year Yes 1 ☐ Yes ∠ ☐ Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 🗌 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work s after death. 2 Accident
3 Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifie D0068080 Janer 11/27/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) agoi medical center Drive Rockville, Maryland 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle Last) 2 Date of Death Physician/ Novembe 201 -0 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimor 10 WSON If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Min (Month, Day, 4088 Director 1 M 2 D F 98 Greece 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked of other than "natural", or items be notified at any luly or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD 10e. Street and Number 10g. Citizen of What Country? Funeral IOINA USA . Was Decedent Ever in U.S. Armer Forces?

1 Ves 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 2011 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 to tis aNdEll 28, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, NOVEMBER 20a. Methor of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 2011 of Funeral Service License 2134 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CEREBROVASCULAR ACCIDENT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on. as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: ate has been signed by the attending page 2 should be detached for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2**X** No 2 No Yes 1 Yes funeral director, Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 Yes 2 X No 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by ☐ Homicide determined 24 hours a Medical 29a. Certifier within 24 hound To the Funer completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 X Certifying Nurse Practitioner: To the best of my Impelledge od at the time. 29b. Signature and title erson who completed cause of death (Item 23a) (Type, Print) JONES, 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) ----

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-28-11 vt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Noveinbe Medical Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death sita 40S Social Security Number In vrs. last birthday If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) 42 Hours Country) 67 Yrs. **Director** 1 M 2 M nce of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2120 New Com 12. Was Decedent Ever Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 oh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other pla 4 Donation 5 Other (Specify) WEral neral bernout dley 21. Signatur ASKEN 2134 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition The Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if they have a statement cause. Enter Underlying Examine Due to (unas e consequence of): Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar APPROVED BY MEDICAL Due to (or as a consequence of): Physician/Medical CERTIFICA Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Month Day Pregnant at time of death 1 ☐ Yes ∠ y 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy 2 🗌 No Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 X Yes မြ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 No M Accident Investigation Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature Res- OCC 30. Name and add who completed cause of death (Item 23a) (Type, Print) MIC 600 North Welfe Street Baltimore 31. Date filed (Month, Day, Year) State NOV 3 0 2011 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Patel Physician/ pkumar November Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death aurel Regional *l* aurel Prince Hospita George's Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days (Month, Day, Year) Country) India **Director** 220-92-9607 61 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Prince George's Maryland Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9108 Elaine Court, Apt. 203 20708 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian Indian 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Machine Operator Mattress Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bhikhabhai Patel Sita Patel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pallavi Patel/Daughter 2305 Dobbins Lane, Irving, Texas 75063 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 26. 1 Burial 2 K Cremation 3 Removal from State west Arundel 4 Donation 5 Other (Specify) 2011 Odenton, Maryland Crematory 21. Signature of Funeral Service Licens 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 M01386 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause or each line. 23a, Part Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, Examiner il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) physician s the burial Physician/Medical abetic Division of Vital Records, P.O. Box 68760 ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 No 3 Probably 4 Ohknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Man or of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury work? after death. Director: Af 2 🗌 No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi D69247 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road 10 V Laurel Regional Hospital Mohamed Tourky 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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11-08821

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Charles Gordon Price	1-	For State	of Maryland		rtment of fificate of			Menta	I Hyg		2 (eg. No.	Ji	1 3810
Physician/ Medical Examiner	1.	gistrar Decedent's Name (First, Middle,Last	Charles	Gord	on Pri	ce				Date of Dea Month Novembe	ith Day Year		3. Time of Death 0640 hrs
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Funeral Director	5.	Social Security Number 6. Se		e (In yrs. Ias 52	st birthday) Yrs	If Under	1 Year	If Under 2 Hours	24Hrs. Min.		oth (MM/DD/YYYY) 5/1959	9. Birth Foreigr Cou	
and show any ace.	1	sual Residence of Decedent Da. State 10b. County Maryland Anne A	rundel	10c. City, 1	Fown or Locat Baltin	nore							10d. Inside City Limits 1 Yes 2 No
to 28a-f sh infocation	1	De. Street and Number 612 Luther Stre	eet			10f. Zip (²¹²²	5			0g. Citizen of Wh		itry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		I. Marital Status Never Married 2 X Married Widowed 4 Divorced	Yes 2				Cuban, I	Mexican, P		cify Yes or No ican, etc.)	White Specify:	e, etc. Wh	can Indian, Black, uite
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Vital F hysician: this certifical director,		5. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2	ER/Outpatien			<u> </u>		Home 5	Residence 6	Other	r: Scene
on of \range on of \range on of \range or \ran		7. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	28a. Date of Inj FOUND: Nov 23, 201	Year)	28b. Time of FOUND: 0615 hrs	Injury 2		vat Work? es 2 ✔ N	ls.	28d. Describe Subject ha	how injury occurr nged self	ed	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral December of the funeral Certification:		3 ✓ Suicide 6 Could not determine	be 28e. Place of I		ome, farm, stre	et, factory,	office bu	ilding, etc.	- 1	or Town,			ral Route Number, City
To the Hosp within 24 hos To the Fune completely fi		9a. Certifier 1 Certifying Physic	ian: To the best of n	amination ar	ge, death occu nd/or investiga	rred at the	time, dat opinion,	te and plac death occu	e, and ourred at	due to the cau the time, date	use(s) and manner e and place, and c	as state	ed. e cause(s)
To with To com	2	9b. Signature and title of certifier	and manner stated		-	290	. License			-	29d. Date sign		
3		0. Name and address of person who Jack Titus MD. Deputy	Chief Medical E	Examiner	900 W.	Baltimo	re Stree	et, Baltir	nore,	MD 21223	3		
State Registra	_	11. Date filed (Month, Day, Year)	32. Registr	ar's Signatu	art								

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sician/ ledical		. Decedent's Name (First, Middle, La Robert Thomas Pa	app				2. Date of De Month	Day 29	2ŏ11	3. Time of Death 2:37 A M
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To Be C	1	7. Father's Name (First, Middle, Last) Andrew Edward Par			Enginee	18. Mother's Na	me (First, Middle	, Maiden Sun	nnolog	У
	1	19a. Informant's Name/Relationship (7 Andrew Papp - SON	Type, Print)	- 1	-	and Number or Ru	ıral Route Numb	er, City or Tov		Code)
200	2	0a. Method of Disposition 1	see Kemin	Metro Cre	ematory or other pla ematory] . Name and Addre 19 Freder	INC 11- ess of Facility Cr rick Road	, Baltin	Bal Socie more,	ty Of	Maryland Maryland I
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Augusta Rice Pulliam Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) 03/03/1941 HOS Himore 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Country)
Maryland 70 Director 214-36-8612 Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 431 Notre Dame Lane #204 21212 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 XX Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Operations Manager Security is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 Edward Dud1ey Vernia Rice other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 Lynn Hoskins / Daughter 309 Limestone Valley Dr. Apt. E, Cockeysville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ō ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) ō Important: I any injury o 4 X Donation 5 ☐ Other (Specify) Uniformed Sers. Univ. 11/22/2011 Bethesda, MD Rapportuneral Famu Cremation Services 933 Gist Ave., Silver Spring, MD M00382 Stoley John 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Retween Onset and Death Immediate Cause (Final Drr Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Dav n signed by the a 1 ☐ Yes 2 **L** 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas After this certificate 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🗲 ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dea.. •al Director: Aftr •vv the fr Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a 1 🚾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

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		_	State Registrar			Cer	tificate of L	Death			No. 2		<u> 38</u>	
	Physicia Medio		1. Decedent's Name (First, Middle	Arth	ar Fr	ederi C <i>H</i>	ck Rauch	Jr.	2. Date of Month		Day / 6	Year	3. Time of 12:	
-	Examin	er	4a. Facility Name (if not institution) 11402 Longhorn	_			4b. City, Town, or Beltsv		Death		4c. County		eorge':	s
	Funeral Director		5. Social Security Number 561–44–5709		(In yrs. las:	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24		f Birth		g. Birtl	nplace (State o	r Foreign
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	rith the M 23a or 28 st be not	ral Dir	10e. Street and Number 11402 Longhorn			22001	10f. Zip Code 207	 05		10g	. Citizen of		untry?	
36	ge 1 and 2 should be filed within 72 hours after death with the Manyland tr of Health and Mental Hygiene. It frem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 🛣 Married 3 Divorced	12. Was Decedent E Armed Forces? ried 1 2 2 1	ver in U.S.		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Origin an, Mexican, F	n? (Specify Yes or Puerto Rican, etc.	No-)		ck, White	ican Indian, , etc. hite	
Baltimore, Maryland 21215-0036	vithin 72 hours iene. r than "natur the Medical I	Completed		nt's Education set grade completed) College (1-4 or 5		(Give life. D	dent's Usual Occup kind of work done o O NOT use retired) ctrical e	during most o	•	16	b. Kind of E	Business I	ndustry	unk
and	be filed v ental Hyg ked othe ic event,	To Be	17. Father's Name (First, Middle, L Arthur Frede:						s Name <i>(First, Mi</i> l erine E.					
Mary	d 2 should alth and M 27 is mar er traumat		19 gun rang Name/Relationsl Jalina Rauch/s	hip (Type, Print) pouse		19b Mailii 1140	ng Address (Street Z Longhor	and Number on Cour	or Rural Route No t Belts	imber, Cit VIII 6	y or Town,	State Zin	63 ^{de)}	
more,	Page 1 anment of He ant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (S			metery, crer	osition (Name of matory or other plac		Date				Town, State	
Balt	permit. Page Department Important: I any injury or once.		21. Signa are Funeral Service	scenses war	ctor		tate Marta altimore,		ard 655 1201	W. E	Baltim	nore	Street	
~	Ph, sician		23a. Park1. Enter the disease, or shock, or beart failure. List of Immediate Cause (Final disease or condition	complications that caus only one cause on each in	the death.					ry arrest,			Approximation interval Bet	
	Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):							77.	
	red nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a conseque	nce of):								
0	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a	a conseque	nce of):								
Box 68760	The law requires that the death certificate be attending bhysic page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown	23c. If yes, outcome 1	2 Fetal	death 3	☐ Ectopic pregnand ☐ Other (specify)	су				ate of del		Year
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<u>a</u>	sician: The la certificate ha irector, page ?	Be C	25. Was case referred to medical examiner?	100					(Check only one)	ies Ze		1 🗀 100	2 2 110	
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o uo	ending sath. or: After he fune	ficate	1 Natural 5 Pendir 2 Accident Investi	ng <i>(Month, D</i> ay gation		injury	worl			noo nom				
Division of Vital	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Il Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		iry - At hom c. (Specify)	ne, farm, str	reet, factory, office			ion (Stree or Town, S		ber or Ru	ral Route Numi	ber,
	he Hospi in 24 hou he Funer pleted fill	Medical	(Check 2 Medical 8	g Physician: To the best of Examiner: On the basis of e g Nurse Praction To the	xamination a	and/or inves	stigation, in my opini	on, death occu	urred at the time,	date and p	place, and d	ue to the	cause(s) and ma	anner stated.
9	To t To t		29b. Signature and title of certified	Lei	Adi	w	Print) Print)	e number	438	29d	Date sign	ed (Month	n, Day, Year)	2011
			30 Name and address of person	who completed cause of d	eath (Item 2	23a) (Type, 1	Defe:	nse i	Huy A	NN.	-pole	5 M	1214	001
	Sta	te	31. Date filed (Month, Day, Year)	11 2 32. Registra	ar's Spnatu	park	1		7		/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ Month P^{M} Elizabeth Margaret Rohol 2011 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Laurel Regional Hospital Laurel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Aug 12, Year) 925 1 🗆 M 2 😾 F Maryland 86 Director 219-22-6407 Usual Residence of Decedent shov 10d. Inside City Limits at 10a. State 10b. County 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 28a-f 1 X Yes 2 No MD Howard Savage 10f. Zip Code 10g. Citizen of What Country? ms 23a or ö 10e, Street and Number Funeral 8525 Fair Street 20763 U.S.A. ral", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify White 'natural" Completed 3 Wildowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home maker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Lilli Margaret Sealock Clifford Ashline 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8525 Fair Street, Savage, Maryland 20763 Charles Rohol 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Nov 30, 11 Dorsey, Maryland Meadowridge Mem Pk 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave., Laurel, Ma Signature of Funeral Service Lensee HW H M00773 Maryland 20707-4389 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Bilateral Multiple Strokes Sequentially list conditions, if any, leading to him recitat cause. Enter Underlying Exami the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events Atrial Fibrillation and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown ed by the a detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Hypertension 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of 24a Was an Hyperlipidemia has performed? Yes 2 X No page 1 Yes 2 No Coronary Artery Disease 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 X Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Director: / Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hin 24 hours af the Funeral Di mpleted filled ir Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I

complet only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nov. 26, 2011 D69430

Registrar

State

7300 Van Dusen Road, Laurel, Maryland 20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

Nega Ali Goji, M.D.

NOV

31. Date filed (Month, Day, Year)

VOID

CERTIFICATE

2011-38111

SEE

CERTIFICATE

2011-36569

completed 12-13-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#10f, perFH, G922, 12715/2011, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month D. PM Physician/ ds 22,2011 man Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner ECIL HEALTHCARE SYSTEM PERRY POINT MARYLAND If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth **Funeral** Feb. 28 Hours Min 1 🛣 M 2 🗆 F 1948 Maryland **Director** 63 214-50-4748 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10a. State 10b. County Director 1 🗆 Yes 2 🎦 No Maryland | Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 21009 Funeral $\frac{21001}{21001}$ USA 3918 Bush Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. 1 Never Married 2 Married 2 No Completed by 21215-0036 1 ☐ Yes 2X No Specify: Specify: If Yes, Give White 3 Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 16b Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Residential Housing Maintenance Technician Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Carmella Mary Azzaro John Daniel Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Rae Williams-Rice/Wife 3918 Bush Court, Abingdon, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11-29-2011 1 XBurial 2 Cremation 3 Removal from State Crownsville Veterans Cem.

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Crownsville Veterans Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) athroof Funeral Service Licens 21. Si 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final MEGNOMA Physician/ MUCELLATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 2 🗌 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: မ 1 Yes 2 No 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 2 🗌 No 1 🗌 Yes Accident
Suicide Investigation 24 hours after deatl 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 20390 OVEMBER Name and address of person who completed cause of death (Item 23a) (Type, Print) VA MARYLAND HEALTHCARE SYSTEM PERRYPOINT, MI

State Registrar

HOM A

DHMH 17 Rev 7/2009

Date filed (Month)

NOV 3

M.D 32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 2011 10:00 p^M Physician/ Rohde November Herman Raymond Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Harford Bel Air 1510 Balmoral Dr. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Dec • 9, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Ohio **Funeral** Days Hours T922 88 282-18-8313 1**X** M 2 □ F **Director** Usual Residence of Deced 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10b. County 10a. State 1 🗆 Yes 2 No Director Bel Air MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21014 Completed by Funeral 1510 Balmoral Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Was Decedent Ever III 0.5.
Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates 1941-64 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White filed within 72 hours after Baltimore, Maryland 21215-0036 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) event, the Me Federal Government College (1-4 or 5+) Elementary/Secondary (0-12) Engineer 4 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Keller permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve and Mental ! is marked o Helen ပ Rohde Henry Herman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21014 1510 Balmoral Dr., Bel Air, MD Patricia Penn / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition □ Burial 2 □ Cremation 3 □ Removal from State Bethesda, MD 11/25/2011 Uniformed Sers. Univ: 4 X Donation 5 ☐ Other (Specify) Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD once. 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between et and Death Immediate Cause (Final disease or condition Vear Demontio Physician/ Medical resulting in death) Examiner troke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events at this independent). Due to (or as a consequence of): Examiner Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Day in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🗗 No 3 ☐ Probably 4 ☐ Unknown page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 X No ဂ္ 1 Yes 28d. Describe how injury occurred 28b. Time of 28c. Injury at work? 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: injury 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation
6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined

P.O. Records, Division of Vital within 24 hours a To the Funeral L

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certif R 106260 use of death (Item 23a) (Type, Print) 30. Name and address of person who cor Baltimore, MD

State Registrar

Boyview Cirde 5505 HOPKINS NOV 3 0 2011

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		-	For State Registrar		aryland		artment of tificate of	Health and Death		Reg. No.	2011	3811	4
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	Examin		4a. Facility Name (if not institution Future Care-In	_			Balti				County of Death		
	Funeral Director		5. Social Security Number 212–20–0254	6. Sex 1 M 2 X F	e (In yrs. las	t birthday) Yrs.	If Under 1 Yea Months Days				9 Birth Cour Ma	place (State or Foreign Tryland	
	ryland -f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc						10d. Inside City Limits 1 1 Yes 2 □ No	
	he Ma or 28a e notif	Director	MD 10e. Street and Number			В	altimor	e		10g. Citiz	zen of What Cou		+
	with t	Funeral	6441 Gilmore S	treet			21:	207			USA	·	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☒ Divorced	If You Give		li li	Vas Decedent of f Yes, specify Cul	Hispanic Origin? (S pan, Mexican, Puer lo Specify:	pecify Yes or No- to Rican, etc.)		14. Race - Ameri Black, White, Specify: W		
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lary	should and N is ma is ma	134	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address (Stree	et and Number or Ri	ural Route Numbe	er, City or	Town, State, Zip	Code)	
	and 2 Health em 27 ther tu		Kevin Larson -P	ersonal Rep	John Bla		orrento sition (Name of	Avenue;	Baltimor Date		D 21229 cation - City or T	own State	-
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altir	permit. P Departme Importar any injur		21. Signature of Funera Sirvice I		ALI	22	, Name and Add	ress of FacilitSte Home of C	rling As	hton	Schwab	Witzke	
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n Ü	h, sician/ Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on each lin	DE	ME	w TIA	ring, such as cardia	c or respiratory an	rest,		Approximate Interval Between Onset and Death	
Sept.	Examiner			Due to (or as	a conseque	J/C	177						
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3	Ectopic pregna Other (specify)	incy			23d. Date of d eli	very Day Year	
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3	To the Hospital or within 24 hours aft. To the Funeral Dir completed filled in	Medica	(Check 2 ☐ Medical only one) 3 ☐ Certifyin	g Physician: To the best o Examiner: On the basis of g Nurse Practioner: To the	examination	and/or inves	tigation, in my op death occurred at	inion, death occurred the time, date and p	d at the time, date:	and place, he cause(s	, and due to the c) and manner as	ause(s) and manner state stated.	ed.
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Division	after after Direc d in by	Cer	4 Homicide	determin			(Specify)	e, farm, stre	et, factory,	опісе			8f. Location (8) City or Tow			er or Rural	Route Nun	nber,		
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	Stat Registra		31. Date filed (Month	n, Day, Year)	111 82. F	Registrar	's Signature	back	2											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 2 U For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Facility Name (if not institution, give street and number) **Examiner** TOS Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Mir **Director** 1 □ M 2 🖼 or 28a-f show death with the Maryland **Funeral Director** 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 Yes 2 No mor 10g. Citizen of What Country? 10e. Street and Number items 23a dag Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married by 2 No Baltimore, Maryland 21215-0036 within 72 hours after Yes If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Completed 3 ₩idowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT user etired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) Be Father's Name (First, Middle, Last) 18. Mother's Name (First_Middle, Maiden Surname ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marken any injury or other traumatic e injury or other traumatic 19a. Informant's Name/Relationship ural Royte Number, City Slaa Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses mua 1133 Part 1. Ence the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a sonsequence bi). if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and I for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 5 Other (specify) 2 No the a Yes 9 Unknown s been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I; page 2 s autopsy perform 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence after death.

Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accider 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after

To the Funeral Direct

completely filled in b Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

Registrar's Sign

Martha	Magdalene	Sprinkle
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		Registrar Certificate of Death		Reg. No.	
Physicia Podical Exami		1. Decedent's Name (First, Middle, Last) Martha Magdalene Sprinkle		Day Year er 26, 2011	3. Time of Death 1159 hrs
		4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center 4b. City, Town, or Location Bel Air		4c. County of Dea Harford	
Funeral Director		5. Social Security Number 219–12–9606 6. Sex 1. Months 2 1. Months 2 1. Months 2 1. Months 2. Mo	To death of the second	28, 1924	Birthplace (State or eign Country) NC
b		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits
Maryland 28a-f show any d at once.	P	MD Harford 10c. City, Town or Location Fallston			1 Yes 2 No
e e	Director	10e. Street and Number 10f. Zip Code 21047		10g. Citizen of What Co U.S.A	
eath with th items 23s	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married Armed Forces?	gin? (Specify Yes or t n, Puerto Rican, etc.)	No- 14. Race - Am White, etc.	erican Indian, Black,
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D 21 should and Mer	ြ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nut			ite, Zip Code)
, MD and 2 sho ealth and rem 27 is	-	Penny Sprinkle (Daughter) 3602 Klasmier Road 20a. Method of Disposition (Name of cemetery,	Perry Hall,	20c. Location - City	or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 Burial 2 XX remation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Atlantic Crematory	12/1/11	Glen Burnie	, MD
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er	1	21. Signature of Fugeral Syrvice Licensee 22. Name and Address of Facility Burgee Henss Seitz 3631 Falls Road B	Funeral Home	Inc.	
Physician	\dashv	23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line.			Approximate Interval Between Onset and
Medical Examiner	1	Immediate Cause (Final disease a. Hip Fracture with complications			Death
.		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
	Examiner	if any, leading to immediate Due to (or as a consequence of): Disease or injury that initiated C.			
uted nd ransit		events resulting in death) Last Due to (or as a consequence of):			
8760, ifficate be executed ng physician and st the burial - transi	n/Medical	X UNPENDED AMENDED 23a,27,28a-f,per me,g923	1-31-12 sm		
8760, ufficate be ng physic as the bur	Ne s	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectop	ic pregnancy	23d. Date of delive	ery Day Year
	iciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		Monar	buy rom
Bo he dear	Physicia	1 Yes 2 V No 9 Unknown 9 Unknown	art 220 Dio	tobacco use contribute	to the cause of death?
on of Vital Records, P.O. Box 6 ending Physician: The law requires that the death cer ath. or: After this certificate has been signed by the attendine the funeral director, page 2 should be detached for use.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P		es 2 No 3 Pr	_
rds, requirements been should	Completed by		24a. Wa		autopsy findings available completion of cause of
tal Reco	티		per	formed? death1	
al R an: T entifica	Be	25. Was case referred to medical 26.Place of Death	(Check only one)		
Litis c	일	Tes 2 No	Nursing Home 5		ner;
Division of Vital Records, ral or Attending Physician: The law requir rs after death, al Director: After this certificate has been sied in by the funeral director, page 2 should the fine of the properties of the properties of the funeral director, page 2 should the funeral director.		27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury around 1 Yes 2	l No	e how injury occurred	
ivision or Atteneather death Director:	cati	2 X Accident Investigation 11-17-141400 hrs	tc 28f Location	t fell (Street and Number or l	Rural Route Number, City
Division pital or Attent our after death ceral Director	Certification:	3	or Town	State) 530 S. Ma	acon St.
Hos Fun Fun	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	ace, and due to the ca	use(s) and manner as st	ated. the cause(s)
To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (M	
		The for M. King TR. W.) O.C.M.E.	OCME	November 29,	2011
Ø		30. Name and address of person who complete cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore St	reet, Baltimore. N	/ID 21223	
S	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis	trar	NOV 3 0 2011 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death Time of Death 330 Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death umbi If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe 6. Sex 7. Age (In vrs. last birthday **Funeral** Nin. Months Days None **Director** 1 🗆 M 2 💢 F Maryland 28a-f shov with the Maryland Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12625 Golden Oak Drive 21042 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.). 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc ò ò 1 X Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nasser Sharara Rihab Saeed other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Nasser Sharara 12625 Golden Oak Drive, Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Columbia Mem. Park 11/29/2011 Clarksville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Juneral Service 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01581 313 Talbott Ave, Laurel, MD 20707 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Dust to for as a nonsequence of cause. Enter Underlying Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 Month Day Year Pregnant at time of death No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2/No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2X No 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other 1 Yes 2 No မ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? after death. 2 🗌 No filled in by the Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ca se of death (Item 23a) (Type, Print) 5755 Truvens Cedar Columbia, MD 21044 Margaret Lane, 31. Date filed (Month, Day, Year) State NOV 3 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 8,20b per fh,g922,12/02/2011dhb Certificate of Death Reg. No. 1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day & Physician/ Month Cleveland B. Scott 2:52PM November 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Sinau Baltimore HOSpitel of Baltimore ly 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, MD 219-07-7363 93 1 M 2 D F Director 09/18/1918 Usual Residence of Decedent show 10a. State with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director or 28a-f sh notified 1 Yes 2 No **Baltimore** MD **Baltimore City** 10e. Street and Number r items 23a or iner must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21215 4601 Pall Mall Road filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates Specify: 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Employee** Steel Company 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked 2 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4932 Lindsay Road Baltimore, MD 21229 Jean Burns Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zien Cemetery

Garrison Forest Veterans Cem 20c. Location - City or Town, State injury or Lansdowne, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Hish Medical Due to (on as a consequence of): **Examiner** mounel 2 weeks Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseq er ce of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION, DEMENTIA, SCHIZOPHRENIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? OSTEW ARTHRITIS. 24a. Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 2 No Other: 1 Yes ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 24 hours after deatle Funeral Director: Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29c. License number anno RESA NOVEMBER 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANU DUGGAI Singi Hospital MBBS 31. Date filed (Month gistrar's Signatur State Registrar

SCE TH

Cleveland

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8:30 PM November Physician/ irginia Medical 4c. County of Death 4a. Facility Name (if not institution, give street and 4b. City, Town, or Location of Death Examiner Medica Cerite Itimore 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 1 Year If Under 24 Hrs. Funeral 1 🗌 M 2 💢 Hours Min. MoMar 26, 4964 Months 47 218-28-7846 **Director** Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland Director **Baltimore Baltimore City** 1 🗌 Yes 2 🗌 No MD 10f. Zip Code 10g. Citizen of What Country? U.S.A. 10e. Street and Number 21223 Funeral **5 North Carey Street** death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black 1 Never Married 2 Married δ 72 hours after 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired)
Employee Candy Co. **Candy Company** Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 18. Mother's Name (First, Middle, Maiden Surname)
Rebecca Clark 17. Father's Name (First, Middle, Last) **Thomas Sterrette** 19a. Informant's Name/Relationship (Type, Print) o. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code)
4206 Standwood Avenue Baltimore, MD 21206 Page 1 and 2 s ment of Health s ant: If item 27 i Mae Dingle 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other plant. Zion Cemetery Nov 28, 2011 Lansdowne, Maryland 4 Donation 5 Other (Specify) 21. Signature Fur al Service Licensee 22. Name Estep Brottiers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on elimmediate Cause (Final sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest he disease, or complications that c MetaSta Phylician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami The law requires that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death page 2 should be detached g 🗌 Unknown signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗆 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certificate 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? iniury 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore M.D 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Patricia Lynn Salvo November 12:03 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5421 Sweet Air Road Baltimore Baldwin If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country) **Director** 21.3-34-0057 Usual Residence of Decedent 1 M 2 X F 74 March 17,1937 Maryland 10a. State 10h County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Maryland Baltimore Baldwin 1 🗆 Yes 2 🔀 No ō 10e Street and Number 10f. Zip Code ms 23a or 10g. Citizen of What Country? Funeral with 5421 Sweet Air Road 21013 **USA** items? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner ō þ 1 Never Married 2X Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", Specify: White Completed 3 Widowed 4 Divorced er than "natur , the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "rany injury or other traumatic event, the Med Once. Elementary/Secondary (0-12) College (1-4 or 5+) Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Claudia O'Daniel Walter Barrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Woolery, Son 1638 Kreitler Valley Road Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/22/11 Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee ²Cremation Society Of Maryland, 299 Frederick Road Baltimore, Thomas Gregor Maryland 21228 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Day Pregnant at time of death Month signed by the a 9 Unknow 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy perforn death? After this certificate I Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No eral Director: A 2 Acciden
3 Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely. (Check dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practitioner: To the best of my knowledge, only one South scoursed at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Novemter ser ban 21:40 PM Year Physician/ hael Medical 4a. Facility Name (if not institution, give street and number Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs, last birthday) 24 Hrs Min. Date of Birth (Menth, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 194-80-5385 1 □ M 2 😾 F Director 38 26, 1972 Romania Usual Residence of Deced show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at with the Maryland **Funeral Director** 28a-f 1 🗆 Yes 2 😾 No CA San Francisco San Francisco 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ms 23a or must be n ö 94109 2001 California St., Apt. Romania death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, ral", or iter Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Caucasian "natural" Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the Research Statistician Financial 5+ of Health and Mental Hygi item 27 is marked other other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Maria Savin Vasile Gheorehe Serban 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 2001 California Ave., Apt. 602, San Francisco, CA 94109 Arjunan Rajeswaran / Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō Department Important: If any injury or Metro Crematory Inc. 11/27/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is interested to the cause (Disease or injury) Examine Due to (or as a consequence of) the burial-transit been signed by the attending physician and should be detached for use as the burial-trai that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Hospital or Attending Physician: The law requires that the death. 24 hours after death. Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page 2 has Yes 2 N funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မ eral Director: After this filled in by the funeral di 28a. Date of injury 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at (Month, Day, Year) Natural Accident 5 Pending 1 Yes 2 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) November 24. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar SONAL

31. Date filed (Month, Day, Year,

32. Registrar's Signature

WOIFE ST

Baltimore MI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2<u>011</u> Kathleen E. Thomas 17 2159 Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PG PG Community Hospital Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min 07-30-1959 579-86-2637 Director Wash. DC 1 🗆 M 2 💢 F 52 Yrs Usual Residence of Decede 28a-f show 10d. Inside City Limits with the Maryland 10a, State 10c. City, Town or Location notified at rector 1 X Yes 2 No Capitol Heights MD PG ö 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? r must be r Funeral 624 Balboa Ave. 20743 USA ural", or items â I Exaπiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. δ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. If Yes, Give Year or Dates Specify: Black 3 Widowed 4x Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DC Government Correctional Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Burrell Scott Mary James 19a. Informant's Name/Relationship (Type, Print)
Trevieta Thomas/Daughter 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 Balboa Ave. Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 11-26-2011 Clinton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that vaused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respirato Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? Yes 2 XNo 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 🗌 Yes 2 1 Inpatient 2 KER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of De nit Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending Investigation Natural Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title certifie 29c. License number 29d Date stoned (Month. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James. *C*atevenis 3001 Hospital Dr. Cheverly, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

NOV 30

parke

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month urne 2011 37 мovembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore Medical Center Towson Greater 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Countryl Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No to more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ò Funeral items 23a 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No permit. Page I and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or any injury or other traumatic event than "natural", or leave in the state of à 1 Never Married 2 Married 1 Yes 2 No Specify: 21215-0036 If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname) ည *lurner* 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place 2011 21. Signature neral Service Licens 22. Name and Address of Facility Home Height MID 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
Lours shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ rocardia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Year 5 Other (specify) Pregnant at time of death the i g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy certificate **Division of Vital** 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA this After thi funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St 21200 -9 C 31. Date filed (Month, Day, Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

NOV

11-08244

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard Michael		Try 1- For State	Stat	e of Maryla					Menta	al Hy	giene	g.5.0.	2	0 1	1 2	011
Physici		Registrar 1. Decedent's Name (Fir	st Middle I	ast)	Ce	піпсаі	te of D	eatn		12	. Date of Dea	eg. No.		<u>U 1</u>	3. Time of Dea	010
Medical Exami		Richard M									Month Novembe	Day r 3, 201	Year		1326 hrs	
		4a. Facility Name (if not	institution,	give street and nu	mber)			City, Town, or L	ocation of	Death			County of		4	
Fundament		7905 Pulaski H			7. Age (In yrs. I	last hirthd		osedale Under 1 Year	If Under	24Hre	8 Date of Ri		Itimore		place (State o	61.
Funeral Director		5. Social Security Numb		XM 2□F	7. Age (iii yis. i		_	Months Days		Min.	Apr 2			Foreign Cour		unk
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, any		10a. State 10b.	County		10c. City	, Town or	Location							- 1	I0d. Inside Cit	
Aaryland 28a-f show 1 at once.	ō	MD	Balt	imore		Re	oseda								1 Yes 2	<u>X</u> No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 7905 Pulas	ki Hi	obway #1	0.7		10	of. Zip Code	1237		1	I0g. Citize	n of Wha USA	t Count	у?	
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eath w	Funer	1 Never Married	2 Marri	A 1 F	_	unk		specify Cuban,					White,		arringer, black	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	울	IF FEMALE: 23b. Was decedent pregi	nant in the		outcome of preg	nancy			7- 272				Date of d	_		
Box 68760 death certificate be the attending physical for use as the bu	틚	past 12 months?	ion in the	1 Live b	irth ant at time of de	2 L eath 5	Fetal c	eath 3 [(Specify)	Ectopic p	pregnand	у	"	lonth	Da	y Ye	ear
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Divisi pital or Att ours after de reral Direct	13	3 Suicide 6	Could n	ot be 28e. Place	of Injury - At h	ome, farm	n, street, fa	ctory, office bu	ilding, etc.	21	3f. Location (Number	or Rura	Route Numb	er, City
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	ŀ	30. Name and address of	f person wh	o completed caus	e of death (Item	/ 1 23a)	(ļ				1				
		Zabiullah Ali, M		sistant Medic			W. Balt	more Stree	t, Baltim	ore, N	ID 21223					
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	Examir	er	4a. Facility Name (if not inst S4'20 Fra	neford	Estal	ec	Y	4b. City, Town,	+MOM	•		4c.	County of D	eath	'
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	Maryland 28a-f shor	Director	MD.	County N/	4	10c. City	BAL	ocation 1/MOVIL	-					100	d. Inside City Limits 1 Yes 2 No
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5-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Di	Married	2. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		5. 13	Was Decedent of If Yes, specify Cu	ban, Mexicar	n, Puerto R	ify Yes or No- ican, etc.)		14. Race - A Black, W Specify:		
21215-(within 72 hou giene. er than "na ti er the Medica	Completed		11			(Giv	edent's Usual Occ e kind of work don DO NOT use retire	e during mos d)	et of working	g	16b. Kii	nd of Busine	ss/Indu	stry mTy
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	and 2 shou Health and tem 27 is m		19a. Informant's Name/Rel	ationship (Typ	e, Print)		54.	iling Address (Stree	AFOR	er or Rural	Po e Number	er, City or	Town, State,	Zip Co	2+20b
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or otl once.		20a. Method of Disposition 1 Burial 2 Cren 4 Donation 5 C		Removal from State		lace of Dispersion	position (Name of ematory or other p	lace)	12-2	2-//	20c. Lo	cation - City	or Tow	n, State
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			29b. Signature and title of c	erti fe	n Do)			0630	195		29d. Date	signed (Mo	nth, Da	y, Year)
	8		30. Name and address of A	erson who cor	mpleted cause of d	eath (Item	23a) (Type,				ore, M	0 2	1239	Ji	ilie Rich,
	Stat	e	31. Date 10 0 3h, 0 2	011	32 Negistra			,					- 7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9922 12-16-11 vt State of Maryland / Department of Health and Mental Hygiene Amend Items 23a per dr., g921 11/30/2011 dbb For State Registrar 38127 Reg. No. 1. Decedent's Name (First, Middle, Last) Eloise Wilson 2. Date of Death 3. Time of Death **Ethel** Day 28 Month November Physician/ 3:30 AM 2011 . Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Flospita gres Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🗗 Yrs. **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show icical Examiner must be notified at 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify. Completed 3 ₩idowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Micrical any injury or other traumatic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, 2 19a. Informant's Name/Relationship (Type, Print) City or Town, State, Zip Code) METRIL 33a Baltimore, № 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donation 23a. Part | Extern the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate
Interval Between
Onset and Death
Approximate
Interval Between
Days Physician/ Gram Positive Septicemia disease or condition Medical resulting in death) Due to (or as a consequence of): 3 Days Pneumonia **Examiner** Sequentially list conditions, in any, leading to minimize date cause. Enter Underlying Examiner Die to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 as IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?
1 □ Yes 2 ₺ No has autopsy this certificate 2 1 25. Was case referred to medical Division of Vital completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Certificate: To 1 🗌 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred : After 1 Natural injury work?
1 Yes 2 No 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) P25485 /28/2011 for 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Baltimore MD Caten avenue 31. Date filed (Month, Day, Year) 2. Registrar's Signature State NOV 3 0

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 38128 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) = Month [1 Day 26 Year 200 WILLIAMS Physician/ 3 AM M €. KENNETH Medical 4c. County of Death

Baltimore O 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 2408 Keveway Court Windsor Mu Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under Hours 7. Age (In yrs. last birthday) **Funeral** Months 1 **X**M 2 □ F MD **Director** 1011 10d. Inside City Limits show or 28a-f show notified at 10c. City, Town or Location Director 1 Yes 2 No Baltimore Windsor 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be rance. USA Completed by Funeral 2408 Kerswar Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Shefferman Biggelsen College (1-4 or 5+) Elementary/Secondary (0-12) Engineer Mechanical 12th grade 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name Virst, Middle, Last) Cobbs ပ Chanene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Road Owings Mills, MD 2117 Keith Williams 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or 1 Burial 2 Cremation 3 Removal from State Greenmount Crematory Battimore, MD 12/01/2011 4 ☐ Donation 5 ☐ Other (Specify) Vaughn C. Greene Furreral Services 21. Signature of Funeral Service Licensee Liberty Road Randallstown MD21133 or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest part failure. List only one cause on each line. 23a. Part 1. Enter the shock, or Onset and Death Immediate Causa (Final Physician/ disease or condition resulting in death) Medical MINUTES Examiner Sequentially list conditions, Be Completed by Physician/Medical Examiner cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury nding physician and use as the burial-tran that initiated events resulting in death) Last 1012 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Cther (specify) Month Day in the past 12 months? 2 🗌 No 1 ☐ Yes 2 L 9 ☐ Unknown been signed by 1 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DISEASE STAGE RENAL 2 No 3 Probably 4 Unknown FLUID OVERWAD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe MO PBi OBEST 2 🗆 No 1 Yes 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ After this funeral of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 27. Manner of Death 1 Natural 5 Pending Accident Suicide Investigation within 24 hours after death

To the Funeral Director: /
completely filled in by the 2 Accident
3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one M 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31960 1105 10753 FAUS ROUSE NO 20 V cause of death (Item 23a) (Type, Print) 30. Name and address of person who co M.D 31. Date filed (Month, Day, Year) Registrar

7

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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			31. Date filed (Month, Day, Year) NOV Q 0 201	32 Registrar	's Signati	ure			1 111111	7	1		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death ient's Name (First Middle | ast) 2 Date of Death Physician/ Day 201 Medical street and number. Name (if not institution Examiner Hospice Baltimore Kaltimore Lo 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min Day, Year, Director 1 🗆 M 2 👿 84 12-20-1926 28a-f show 10d. Inside City Limits notified at Funeral Director Istown 1 Yes 2 No 0 10g. Citizen of What Country? must be i 23a items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status other traumatic event, the Medical Examiner Black, White, etc. 0 Completed by 2 No 1 Never Married 2 Married Yes Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industr ify only highest grade completed) (Give kind of work done during most of working ine. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Be 0 State, Zip Code) 21133 Randallstown, MD t of Health a 460a (altimore, 20a. Method of Disposition Place of Disposition (Name of Department of Important: If it any injury or o once. Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovasa Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence or). the burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 use as t IF FEMALE 23c. If yes, outcome of pregnancy
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4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
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1 Yes within 24 hours after death.

To the Funeral Director; After this certificate 2 No 25. Was case referred to medical To the Hospital or Attending Physician: filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 N Other (Specify) Inpotent Hosp 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Investigation Could not be Accident 3 Suicide 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Chensa wine RI25 808 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste Ylos Lew 15 CRNP N Charl 701 31. Date filed (M 3 0 2011 32. Registrar's Signature State Registrar

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	Fun Direc	eral ctor		5. Social Security Number 6	5. Sex 7. Age 1 ☐ M 201 F	e (In yrs. lasi	t birthday) If Ur Monti		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	Country)	e (State or Forei	
	and works	at	ō	Usual Residence of Decedent 10a. State 10b. County	,0	10c. City,	Town or Location			[April .	3, 1434	MOria 10d.	h lobage Inside City Limit	_
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Baltimore,	Page 1 nent of ant: If it	ury or o		1 ■ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp.		cen	ice of Disposition (I metery, crematory (W		12	5 2011	Pike	SVILL	e, Mi	,
Balt	permit. Page 1 and 2 sh Department of Health al Important: If item 27 is	any inju		21. Signature of Funeral Service Lic	en	1001	22. Name	and Address	2 10 1	Height	- Fw	Pah	6. MD	e
		4		23a. Part 1. Enter the disease, or conshock, or heart failure. List only	omplications that caused ly one cause on each line	I the death.	76.					In	oproximate terval Between	
Ĉ	Physici Med	lical		Immediate Cause (Final disease or condition resulting in death)	a. Due to 7 r as a	a constitue	homq						nset and Death	
	Exami		Jer	Sequentially list conditions, if any, leading to immediate	b	a conseque	nce ofi:					_		
	be executed sician and	transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C. — Dun to (or or		,							
00	e be executed ysician and	puri	l g	resulting in death) Last	Due to (or as a	1 conseque	nce on.				***			
9289	ertificat ding ph	se as th	/Med	IF FEMALE:	23c. If yes, outcome	of pregnance	CV				22d Do	ate of delivery		
Вох	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physic the Funeral Director.	thed for u	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal o	death 3 🔲 Ectop					onth Da	y Year	
P.O.	s that th	9	ρ	Part II. Other significant condition	s contributing to death b	ut not result	ting in the underlyi	ng cause giver	n in Part I.		obacco use cont			
Records,	require been sign	plnod:	Completed							1 LJ 24a. Was		Were autopsy	findings availab	le
Rec	sician; The law i	director, page 2	Comp							auto perfo 1 Yes	rmed?	prior to comp death? 1 Yes 2	letion of cause o	f
Vital	ician	rector	m	25. Was case referred to dical examiner?	Hospital:			26. Place Other:	e of Death (Chec	ck only one)		10	2719	0
of V	Phys r this	<u>~</u>	<u>۾</u>	1 Ll Yes 2 No 27. Mann f Death	1 L Inpatie	ry 2	R/Outpatient 3 -	28c. Injury a			dence 6 Oth			
ono	ending Physath.	he fun	ficate	1 Matural 5 Pending 2 Accident Investiga	ation	, Year)	injury M	work?	es 2 🗆 No	200.000.00				
Division	al or Attendi s after death.	ed in by the	Certificate:	3 Suicide 6 Could no 4 Homicide determin			e, farm, street, fac	tory, office		28f. Location (S City or Tov	Street and Number vn, State)	er or Rural Ro	ute Number,	
_	To the Hospital or A within 24 hours after To the Funeral Direct	letely filli	Medical	(Check 2 L Medical Exa	Physician: To the best of aminer: On the basis of extension of the basis of extension of the basis of the bas	xamination a	and/or investigation.	in my opinion,	death occurred a	at the time, date a	and place, and du-	e to the cause		ated.
	To the Within	сошо		29b. Signature and title of certifier	Xh.) Door or my		29c. License n) -7	29d. Date signer			_
)		ł	30. Name and address of person wh	no completed cause of d	eath (Item 2	(Type, Print)	0/1	58/	0	100	27,	2011	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Nellie L. Williams 2:00 A M CVEND Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospita Baltimore Agnes Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number If Under 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Mar 7, 1919 1 M 2 XF Months 92 214-22-2997 Yrs Director Usual Residence of Decedent 28a-f shor 10a. State 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No **Baltimore** Relay MD ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21227 U.S.A. 1724 South Rolling Road death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc \$ 1 Never Married 2 Married 1 ☐ Yes 2 H No Specify: Black Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Employee** Eastern Products 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Priscilla I. Williams Joseph A. Williams Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1724 South Rolling Road Relay, MD 21227 **Denise Williams** 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State emetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Nov 30, 2011 Baltimore, Maryland **Arbutus Memorial Park** 4 ☐ Donation 5 ☐ Other (Specify) Sign dury of Everal Service 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ch line. 23a. Part 1. Enter the disease, or complications that Approximate shock, or heart failure. List only one cause on ea Interval Between Onset and Death Immediate Cause (Final Physician/ lesenteric disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate ducc. E. car Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year signed by the a Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 以(// つから, Nell(c Division of Vital Records, cate has been sig ; page 2 should b 1 🗌 Yes 2 SNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No 1 Yes Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Other: 2 🗶 No 은 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 X Natural 1 Tes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MD 23 and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD

Registrar DHMH 17 Rev 7/2009

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howas 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38133 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOV 2011 Martha Ann Wiggins 26, 6:50 P^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 17502 Bunker Hill Road Parkton Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, 085-14-1703 1 □ M 2 🙀 F **Director** 89 Dec. 16, 1921 Yrs. New York Usual Residence of Deceden 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗆 Yes 2 😾 No Maryland **Baltimore** Parkton 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 17502 Bunker Hill Road 21120 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ David Wood Frances Crowe permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Ann Ely/Daughter Rock Point Rd., Burlington, Vermont 05408 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 11/28/2011 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of Facility Cremation Society of Maryland Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus on each line. Approximate Interval Between set and Death Immediate Cause (Final Ph, sician/ WW disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 anding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 month 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death the ¿ g Unknown 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an ate has bage 2 s perform 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Desidence} \) 6 \(\text{Other (Specify)} \) 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death **To the Funeral Director:** А сотрletely filled in by the f Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖖 😅 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NOV 28, 2011 ress of person who completed ca Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ : 25 M #CK Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Balto Randallstown 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Hours Min 185-20-6812 Director 1 X M 2 - F 1927 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director Baltimore 1 Yes 2 No Randallstown MD o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 9109 .5 -iberty 21133 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry h and Mental Hygiene.
7 is marked other than "n (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) UNK operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Page 1 and 2 should be t ment of Health and Ments CNK CINK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27 of Baltomore_ Agenna Shana Dept Baltimore ST MD 21202 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1

■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11-16-11 emarmel 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Advance disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury to use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 NA IF FEMALE: NA NA 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 9 Unknown þ Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed to should be det by Basal Gu Cancer 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a Was an autopsy has page NIA 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 ANO 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) NIA Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 A certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number D0072109 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SADIA N BAOM Randalls town 21133 BACOM Road 9109 Liberty

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24, 2011 Helen Leone Zimmer November 5:15a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harmony Hall Columbia Howard Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Min Hours Country) 062-12-9867 96 Director 1 □ M 2 🖺 F May 14, 1915 PA Usual Residence of Decedent show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 6336 Cedar Lane, #319 21044 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates White 1 Yes 2 XNo Specify. Specify 3 ₭ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th 12 Housekeeper Boarding School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ traumatic James Smith Rachel Ritchey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shi Department of Health an Important: If item 27 is any injury or other trau once. Susan L. Davis/ Daughter 9556 Glen Ridge Dr., Laurel, MD 20723 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 28, 2011 Odenton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 1, Kein M01053 313 Talbott Ave., Laurel, MD 20707 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Embolic Stroke Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a nonsequence off Exami the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician al s the burial-1 Physician/Medical Box 68760 ast attending IF FEMALE: nse 23b. Was decedent pregnant Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔼 No ó Day Month Year Pregnant at time of death the 9 Unknown P.O. ģ s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2★★No 24a. Was an has page 2 autopsy performed? Yes 2 X No of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2X XNo ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6XXOther (SpecifyAssisted Liv this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division eral Director: A ☐ Accident ☐ Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Framiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV30

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30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

2011

Registrar DHMH 17 Rev 06-2011 Andy Lazris, MD, 6334 Cedar Lane, Suite 103, Columbia, MD 21044

2. Registrar's Signature

29c. License numbe

D47447

29d. Date signed (Month, Day, Year,

November 28, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 ANDAS Physician/ Month November 25 Zoil 08.10 AM EDITH 707 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARFORD HARFORD MEMOURE HAURE DE GRACE HOSI ITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 03/0442-32-1634 1 □ M 2 🕱 F Hours 77yrs yrs. Director OK Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Meck al Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Churchville 1 Yes 2 No MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21028 USA 3102 Woolsey Drive Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc ģ 1 Never Married 2 X Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: If Yes, Give Completed 3 Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) ite DO NOT use retired) Homemaker College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker 4yrs Be 18. Mother's Name (First, Middle, Maiden Surname)

Jewell Fox 17. Father's Name (First, Middle, Last) ပ Kit Brewer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3102 Woolsey Drive Churchville MD 21028 Stephen Zardas Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Atlantic Crem 11/28/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv Thoms ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition resulting in death) WEEKS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E. ter Underlying Due to (or as a consequence of) Cause (Disease or linjury Exam that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕅 No Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 D signed by the a 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ AND HYJERTONVIVE HEART DIVEARE Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ATMAR FIRRICLATION, INNITATION ROUTL 24a. Was an cate has page 2 s autopsy performed? STUDROME 1 Yes 2 No this certificate 1 Yes 2 No Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certificant Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: iniury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after der To the Funeral Director completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVETTRER. 25 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAVRE de CRACE METONIAL HUSSIFAL JWE 4FM HALFOLD

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Please	e Type or Pri							egible.	
		For State		State of M	larylan		artment of F		Mental Hyg	giene		
		Registrar	Territory I.	41		Cei	rtificate of D	eath		Reg. No.	201	1, 38138
Physicia		1. Decedent's Name							2. Date of Dea Month Novembe	Day	2011	3. Time of Death 10:00 P M
Medica Examine				re street and number)			4b. City, Town, or	Location of Death	INOVERIDE		ounty of Dea	
)		Renaiss	sance Ga	rdens			Silver	r Spring		Pr	ince C	George's
Funeral Director		5. Social Security No. 278–12-		Sex 7. Ag 1 □ M 2 🏻 F	ge (In yrs. Ia	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 2	Year)	g. Bii Cc Or	rthplace (State or Foreign ountry) 110
o d		Usual Residence of 10a. State	Decedent 10b. County		140. 00							10d. Inside City Limits
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ter death , or items miner m		11. Marital Status 1 □ Never Marri	ied 2 🗆 Married				Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Black, Whit	erican Indian, te, etc. hite
urs af tural",	Completed by	3 🔀 Widowed		If Yes, Give Year or Dates.			1 ☐ Yes 2 🔀 No			Sp	ecify: W	
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within glene. er tha		Elementary/Seco	onday (0-12)	College (1-4 or 5+	5+)		omemaker			Но	me	
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uld be d Men marke natic				ph Hamper		T			Mary P			
nd 2 sho ealth an m 27 is I			Allen /			215	ng Address (Street a Black And			svill	e, MD	21108
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Durial 2 4 Donation		Removal from State	, c	emetery, cred tro Cr		INC. NOV	Date . 08, 2011	Balt	timore	-
permit. Departimport any inj once-		21. Signature of Eur	neral Service Lice	nsee		E Z	2. Name and Addres Barranco & 195 Ritchi	Sons, P	.A. Seve	erna l	Park F	Tuneral Home MD 21146
		23a. Part 1. Epter t	the disease, or con	nplications that cause one cause on each lin	d the death	h. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between
Physician/		Immediate Cause (disease or condition	(Final				Cardiova					Onset and Death Unknown
Medical Examiner		resulting in death)		Due to (or as Hypert								11
ted Insit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate rlying iinjury	Due to (or as	a consequ	uence of):						
€ ië ië	a	that initiated events resulting in death)		C. Due to (or as	a consequ	uence of):						
icate I g phys	ledic		-	d								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 № 9 ☐ Unknown	months? No	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 Feta	al death 3 [☐ Ectopic pregnand ☐ Other (specify)	у		23	d. Date of d Month	elivery Day Y ear
requires that the de been signed by the should be detached	y Ph	Part II. Other signif	ficant conditions	contributing to death	but not res	ulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use	contribute t	to the cause of death?
luires l	ed b	Atrial	Fibrilla	ation					1 🗆 '	Yes 2 🗆	No 3 🗆	Probably 4X Unknown
sician: The law rec s certificate has bee lirector, page 2 sho	mplet								24a. Was autop perfo 1 Yes	osy	prior to	utopsy findings available completion of cause of
an: Th tificate tor, pa	Be C	25. Was case referre	ed to medical				26. Pl	ace of Death (Chec		2 (A) No	1	es 2X No
ysician: iis certific director,	일	examiner? 1 Yes 2	X) No	Hospital: 1 Inpat	tient 2 🗆	ER/Outpatie	ent 3 DOA Othe	er: 4 X Nursing H	ome 5 Resid	dence 6	Other (Spe	ecify)
nding Pk ath. r: After th ie funeral	Certificate:	27. Manner of Deatl 1 X Natural 2 ☐ Accident	h 5 Pending Investigati	28a. Date of inju (Month, Da		28b. Time o injury	work	y at :? Yes 2 □ No	28d. Describe h	ow injury o	occurred	
To the Hospital or Attenwithin 24 hours after deat To the Funeral Director completed filled in by the	Certif	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine		jury - At ho tc. (Specify	ome, farm, st	reet, factory, office		28f. Location (S City or Tow		Number or R	ural Route Number,
ne Hospit n 24 hour ne Funera pleted fille	Medical	(Check 2	Medical Exa	nysician: To the best of miner: On the basis of ourse Practioner: To the	examination	n and/or inves	stigation, in my opinio	on, death occurred a	at the time, date a	ind place, a	nd due to the	e cause(s) and manner stated
To the within Comment of the the comment of the the comment of the the comment of the	-	29b. Signature and	title of certifier	mmel	Oc.	RUK	29c. License	number Skole	7	29d. Date	gigned (Mon	nth, Day, Year)
418			ess of person who	completed cause of CRNP 31	death (Item	acefie	Print) eld Road (Silver Sp	oring, M	/ D 209	04	- ,
Stat		31. Date filed (Mont	h, Day, Year)	32. Registr		ture .	harles			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38139 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Authers Goldie Maude 2011 1:50 P November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Williamsport Nursing Home Williamsport Social Security Number If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Hours Min (Month, Day, Year, 94 Director Marvĺand 212-14-7237 916 Dec Usual Residence of Deceden 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d Inside City Limits Director 1 X Yes 2 ☐ No Maryland Washington Williamsport ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 154 North Artizan Street 21795 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. ö 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Specify White 3 X Widowed 4 ☐ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 8 Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked or မ Maude Gabe Harry R. Palmer ige 1 and 2 should but of Health and Mer It, If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 Sunbrook Lane, Hagerstown, Maryland 21742 Doris Wisler/Niece Baltimore, 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Department o Important; If any injury or injury or 4 Donation 5 Other (Specify) 11/15/2011 Hagerstown, Maryland Rose Hill Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike, Boonsboro, Maryland 21713 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ ADVAUCE SENILE disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions Due to for an a convectionne of cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami andtran Due to (or as a consequence of) resulting in death) Last sician a Physician/Medical that the death certificate be Box 68760 phys attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death the 9 Unknown P.O. s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician; The law requires Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page perform death? certificate 2 No 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? thin 24 hours after death.
the Funeral Director: After mpleted filled in by the fun 2 🗌 No Investigation
6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death or courred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jovemsen

DHMH 17 Rev 7/2009

State Registrar

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WILLI AMS PORT

30. Name and address of person who completed cause of death (Item 23a) (Type

32. Registrar's

HOWE

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 4 2011 0240 Sadie E. Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Genesis Elder Care Severna Park 8. Date of Birth Jan 13 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Maryland 217-26-3461 Director 1 □ M 2**X** F 89 1922 show or 28a-f shov e notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Anne Arundel Gambrills 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 2566 Shorter Rd. 21054 USA and Mental Hygiene. is marked other than "natural", or items: aumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: B1ack 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Goddard Space Elementary/Secondary (0-12) College (1-4 or 5+) Custodian Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Howard Catherine Moulden permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Bowie(Niece) 2566 Shorter Rd. Gambrills, Md. 20a. Method of Disposition 20b (Placeof Displaying Appe of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Memorial Park 11-9-11 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) Wmane Reeseof & Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ement Medical or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires the within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide Investigation 24 hours after deau Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veterans Hay Millers ville

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

NOV 08

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7/5 M Wilseydee M. Brady OV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LOTHIAN AA 623 Ard LOAd Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 □ M 2XX F Days Min (Month, Day, Year) 2/28/1927 563-36-3376 Director 84 CA Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes XX No Lothian Anne Arundel ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 20711 623 Bayard Rd. items 2 permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒☒o If Yes, Give Year or Dates. . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XXIo Specify. Specify ¾XWidowed 4 □ Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John McAnally Pearl Branum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilseydee Walter daughter Shady Side, MD 20764 1611 Winters Ave. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/8/2011 Owensville, MD Christ Church ion 5 Other (Specify) Signature of Funeral Sen 22. Name and Address of FacilityHardesty Funeral Home, P.A. Licensee Annapolis, MD 21401 Ridgely Ave. Fart / Enter the direa /s, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest / ho /k, or heart fail re. List only one cause on each line. Approximate Interval Between Imn edi ite Cause (Fina Physician/ di eas or condition re ult g in death) Medical Due to (or as a consequence of Examiner NCTION u Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 4 Pregnant : 9 Unknown Pregnant at time of death Yes 2 No detached 9 Unknown ed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be o TAILUNE 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 🗆 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending UN KM work? FAIled FistulA 11 24 hours after death Funeral Director: A Investigation filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Place or my building, etc. (Specify) determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune (Check the only one) eputy 29c. License number 29d. Date signed (Month, Day, Year, 0

Sta

State Registrar 31. Date filed (Month, Day, Year)

Name and address of person who completed

nth, Day, Year)
NOV 0 8 2011

32. Refistrar's Signature

Registrar's Signature

of death (Item 23a) (Type, Print)

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		4	For State	State of Maryland		artment of I tificate of a		ind Mental Hy	Reg. No.	11 38142
			Registrar 1. Decedent's Name (First, Middle, Last)				Joann	2. Date of De	eath	3. Time of Death
	Physicia Medic	al .		old Robinson	Bruno				er 8 2014	3.101
	Examin	er	4a. Facility Name (if not institution, give stre	eet and number)		4b. City, Town, o		f Death	4c. County of De	
	Funeral		Suburban Hospital 5. Social Security Number 6. Sex 328-22-0661	7. Age (In yrs. Ia		If Under 1 Year Months Days		24 Hrs. 8. Date of Bi		Birthplace (State or Foreign
<u> </u>	Director	ŀ	Usual Residence of Decedent	M 2 L F 83	Yrs.			1000. 2	J, 1920 11	
	yland -f shov ied at	ctor	10a. State 10b. County		hevy (10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ith the Ma 3a or 28a t be notif	, <u>≒</u> L	Maryland Montgomer 10e. Street and Number 3414 Cummings Lane	y	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip Code	 0815		10g. Citizen of What United St	Country? ates
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ		2. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Kore8		Vas Decedent of If Yes, specify Cub	an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - Ar Black, Wl Specify: W	
Baltimore, Maryland 21215-0036	in 72 hours e. nan "natur Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	ation	16a. Deced (Give life. D	dent's Usual Occu kind of work done O NOT use retired	during most)		16b. Kind of Busines	
nd 21	filed with tal Hygien d other the	a)	17. Father's Name (First, Middle, Last)	4 old Robinson		urnalist	18. Mothe	r's Name (First, Middle	, Maiden Surname)	C News
aryla	should be and Men is marke sumatic	-	19a. Informant's Name/Relationship (Type		19b. Mailii	ng Address (Stree	t and Numbe	r or Rural Route Numb	er, City or Town, State,	Zip Code)
e, ⊠	and 2 s Health sm 27 ther tra		Harold Bruno, Son 20a. Method of Disposition	20h P		Hudson esition (Name of	Street	Denver,	C0 80220 20c. Location - City	or Town, State
mor	O 4- h		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	G	emetery, crei copoli	natory or other pla tan Crem	atorv	11/8/11	Alexandr	
Balti	permit. Page Department Important: I any injury o		21. Si nature of 5 ne di Service Licensee	11011	2	orehimsk 54 Carro	eys defeator	ew Funeral	Home nington, DC	20012
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death	n. Do not ent	er the mode of dy	ing, such as	cardiac or respiratory a	arrest,	Approximate Interval Between
paralle.	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Complicati	on c	of GF	actur	e after a	fall	Onset and Death
and a	Examiner		S. unitially list conditions. b.	A noxi'C	ence oi):	ephalo	path	W		omt
	executed an and rial-tracet	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Complicat Due to (or as a consequence of the complicat) Due to (or as a consequence of the complete of the c	uence of):	teny i)isea	se	1 10	P
00	icate be executed g physician and as the burial-traceit		resulting in death) Last	Cardiac	,	piratur		rest	Rem	11/9/11
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bure.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	c. If yes, outcome of pregnation 1 Live Birth 2 Fets 4 Pregnant at time of g Unknown	aldeath 3	Ectopic oregina Other (specify)	ncy	ND	23d. Date of Month	delivery Day Year
s, P.O.	ires that the signed by d be detac	d by Ph	Part II. Other significant conditions cont	ributing to death but not res	ulting in the	underlying caus	give Part			e to the cause of death?
Division of Vital Records,	he law requ te has been age 2 shoul	Completed by						24a. Wa aut per 1 🗌 Ye	opsy prior formed? deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
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f Vi	Physic this c	2	1 X Yes 2 No	1 Mnpatient 2 28a, Date of injury	28b. Time o	ent 3 🗆 DOA	4 L N		sidence 6 Other (See how injury occurred	pecify)
ouo	ending eath. or: After he fune	ficate	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) 11/3/11	11:00	Рм	ork? □ Yes 2 🛚		out of Cha	
Divisi	tal or Att rs after de al Directo ed in by t	al Certificate:	4 Homicide determined	28e. Place of Injury - At he building etc. Specification of Specification of the second of the secon	js Ln.	Chevy C	hase,	MD City of I	(Street and Number of own, State) Home	
	Hospi 24 hou Funer eted fill	Medical	(Cheek 2 Modical Evamine	er: On the best of my knower: On the basis of examination	n and/or inve	stigation in my on	nion, death o	ccurred at the time, dat	e and place, and due to	the cause(s) and manner stated
	within To the comple	2	29b. Signature and title of certifier			29c. Lice	nse number	7.	29d. Date signed (M	
	10+1	L	20 Al and address of paragraph who are	aploted cause of death (Iter	n 23a) (Tyme	Print)) . # h	1	
			Natalia Vasquez, M	32 Registrar's Signa	d Geor	getown R	oad, t	setnesda, N	7IU ZUO14	
	Sta Registr		NOV 14 2011	Perus A	1. As	while.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Time of Death Physician/ 7, 201¹1 4:05 November рΜ Desmond E. Brathwaite Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Hospice-Casey House Rockville 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Hours **Director** 1 ☒ M 2 ☐ F 578-72-3999 76 Yrs May 27, 1935 Barbados Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City. Town or Location Director 1 Yes 2 X No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? Street and Number Funeral 20902 USA 3301 Medway Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 K No Black, White, etδ Q 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Eudora Miller Cecil Brathwaite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3301 Medway Street, Silver Spring, MD 20902 Thecla Brathwaite/Wife Date 15, 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of Nov cemetery, crematory or other place) 1 ABurial 2 Cremation 3 Removal from State permit. Page Department or Important: If any injury or Gate of Heaven Cemetery 2011 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francis Adress of Filins Funeral Home Inc. MD 20901 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovascular Accident disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list nonditions Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L Completed by 1 Yes 2 No 3 Probably 4X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an autopsy After this certificate has performe Yes 2 K N within 24 hours after death.

To the Funeral Director. After this certific frompletely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospice Be Other: 1 ☐ Yes 2 X No 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar (Check

only one)

29b. Signature and

30. Name and address of

3 🗆

G. Coleman, MD

31. Date filed *(Month, Day, Year)* **NOV 1 4 2011**

1355 Piccard Drive, Rockville, MD 20850 🗗 2. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

Certifying furse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State of Waryla State Registra MEND#SperFH, 11/17/11; EWW, Mooo 38144 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10,2011 Physician/ Month 9:45pM Lillian N. Becker November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) 577-18-9838 Director 4 🗵 M 2 🛛 F 94 July 19, 1917 Lithuania Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director otified 1 Yes 2 X No Bethesda Maryland Montaomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 6530 Democracy Blvd. 20817 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🗓 No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. National Institutes Elementary/Secondary (0-12) College (1-4 or 5+) of Health Writer/Editor of Health and Mental Hygintem 27 is marked other other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rochel Lipazsky Samuel Nachamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 5630 Old Chester Road, Bethesda, Maryland 20814 Gary Becker - Son altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Judean Mem. Gardens 11/13/2011 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signature of Funeral Service Licensee AnneMane Warm 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Ph_sician/ Aspiration Pneumonia disease or condition Medical resulting in death) **Examiner** Intracranial Hemorrhage 2 Days Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of): signed by the attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Clostridium Difficile Infection 24a. Was an To the Hospital or Attending Physician: The raw within 24 hours after death.

To the Funeral Director: After this certificate has for the Funeral Director. After this certificate has £ 2.5. autopsy performed? 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29c. License number 29d, Date signed (Month, Day, Year) 0 D0053281 November 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 Elizabeth Kang,

Registrar

DHMH 17 Rev 06-2011

State

NOV 14 2011

PM

Becker, Lillian

32. Registrar's Signature

Amend AACO He	#1 alth	8, Depo	17 per FD Pleas t. 11-17-11 KAH									egible.		
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	ysicia Medic	n/	1. Decedent's Name (First, Middle, L Grace Cloo	ast)						2. Date of De Month 11		.1 Year	3. Time of Death 12:30p M	
-	xamin	er	4a. Facility Name (if not institution, give street and number) Heritage Harbour Health & Rehab. 4b. City, Town, or Location Annapol						is			unty of Deat ie Aru	ndel	
	neral ector		563-78-6527 1 M 2 2 2 3 4 5 7 5 7 5 1 1 M 2 2 2 3 5 7 5 1 1 M 2 2 2 3 5 7 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						Min.	8. Date of Bir (Month, Da 12/13/	ay, Year)	Co	9. Birthplace (State or Foreign Country) Minnesota	
aryland	fied at	ector	Usual Residence of Decedent 10a. State 10b. County MD Anne A	rundol		, Town or Loc	ation			l <u>. </u>			10d. Inside City Limits	
with the M	st be not	Funeral Director	10e. Street and Number 1849 Kings P		CIO	LUII	10f. Zip Code 2111				10g. Citizer		ountry?	
d 21215-0036 ed within 72 hours after death with the Maryland Hygiene.	Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	12. Was Deceded Armed Force 1 Yes 2 If Yes, Give Year or Date	XX _{No}		Vas Decedent of Yes, specify Cul			ecify Yes or No- Rican, etc.)		Race - Ame Black, White	rican Indian, e, etc. White	
21215-0036 within 72 hours after giene.	event, the Medical Exa	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		or 5+)	(Give F	ent's Usual Occu ind of work done O NOT use retired emaker	during mos	st of worki	ing		of Business,	Industry (Industry	
land be filed vental Hyg	ic event,	To Be	17. Father's Name (First, Middle, Las		asper					e (First, Middle,				
Maryland 2121	traumat		19a. Informant's Name/Relationship Marguerite Borg	(Type, Print)		I	g Address (Stree	t and Numb	er or Rura	l Route Numbe	er, City or Tov	_	c Code)	
Baltimore, bermit. Page 1 and Department of Hea	any injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐ Removal from St	tate 20b. Pl	ace of Dispo	sition (Name of patory or other pi	ace)	[Date 3/2011	20c. Locat	,	Town, State	
Balt permit. Departr	any inji		21. Signature o Fundal Service Lice	isee	-		Name and Add	ress of Facili	Haro Anı	lesty F napolis	uneral , MD 2	140Te	, P.A.	
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Division the Hospital or Attent hin 24 hours after deat the Funeral Director:	completely filled in by the funer		4 Homicide determine	28e. Place of	f Injury - At hor , etc. (Spec <i>ify)</i>		et, factory, office ng Home			City or To			ral Route Number,	
he Hospi in 24 hou he Funer	pletely fil	Medical	(Check 2 D Medical Exa	hysician: To the bes miner: On the basis urse Practitioner: T	of examination	and/or invest	igation, in my opi	nion, death o	ccurred at	the time, date	and place, and	d due to the	cause(s) and manner stated.	
To the within To the	СОП		29b. Signature and title of certifier	(pr	\sim		1	lise number	17		11	gned (Mont	h, Day, Year) 9 (
CHI			30. Name and address of person wh			23a) (Type, P	rint)	ive-	Surfa	= (-A	t. Ar	maje	(is MD2140)	
Re	Stat egistra		31. Date filed (Month, Day, Year) NOV 082	011 32. reg	ide wer	3. p	uks				1 61)	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 31ay 201^Y1ar Physician/ Clark 8:45 P M Willie Η. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Hours 06/25/1945 Oklahoma 1**X**(X) M 2 □ F 66 441-44-5153 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 XX/es 2 No Carter Ardmore 0klahoma 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 1115 Tenth Avenue S.E. 73401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 Black 1 Yes XX No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) years Elementary/Seconday (0-12) Professor Education permit. Page 1 and 2 should be filed. Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumair. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Willie Clark Sr. Dorothy Barnett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10137 Prince Place #103 Upper Marlboro, MD Marie Clark / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 X Removal from State 11/14/2011 Ardmore, Oklahoma Clearview Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatur of Funeral Service Licenses 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CLL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death Other (specify) 1 ☐ Yes ∠ ∟ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has death? performe page 1 ☐ Yes 2 ☐ No Yes 2 completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Denth 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident iniury work? 5 Pending Investigation s after death Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causes 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29c. License number 1069297 30. Name and address of cerson who completed cause of death (Item 23a) (Type, Print) 20909 KASHIF ALI, MD medical Park Mile 200 2101

State Registrar 31. Date filed (Month, Day, Year)

NOV 0 8 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 38147 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Kai November 6, 3:37PM Choi 2611 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional Hospital -durel Prince aure If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Months $Ju1y^{(Month,Day,Year)}$ 578-60-9439 90 **Director** China Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fijury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No P.G. Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3125 Calverton Blvd. 20705 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force 2 Black, White, etc 1 Never Married 2 K Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Asian 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gat Lung Choi Kim Kau Ng 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wai Kuen Chu/Daughter 3125 Calverton Blvd., Beltsville, MD 20705 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 2 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Noy 11 Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD 21. Signature of Funeral Service Licensee Francis Address of FCO11ins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ POXId Medical resulting in death) Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. (Discours or list) Examiner sician and burial tensit eptic Shock Cause (Disease or linjury that initiated events that the death certificate be executed Due to (or as a consequence of resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month Day ed by the detached P.O. I been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Encephalopathy To the Hospital or Attending Physician: The law requires Records, 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autonsy Fibrillation of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

to the Funeral Director: After thi 27, Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 D Pending injury Division 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi D0012962 Laurel Regional 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loraydd Lee-7360 Van Düsen 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 7/2009

1 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38148 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edwin A. Canine November 2011 1:54 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis . Social Security Number If Under 1 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) 82 **Director** 220-40-7459 1 **X** M 2 □ F June 12, 1929 Oklahoma Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Crofton 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21114 1609 Earlham Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1952 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Nat'l Security Agency Personnel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ruth Wiscomb Ralph J. Canine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Virginia M. Canine - Spouse 1609 Earlham Ave., Crofton, MD 21114 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 11/4/2011 Baltimore, MD Service Licensee Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) (ancel Medical as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 Yes 2 Unknown Unknown s been signed by the should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 本 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? this certificate has 2 🗌 No 1 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Praditioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and and address of person who comp 2001 Medical Parkway

DHMH 17 Rev 06-2011

State

Registrar

NOV 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate of Death	Reg. No. 2011 3814
Physici dical Exami		Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year November 8, 2011 3. Time of Death 1310 hrs
dicai Exami	ner	Dennis Keith Cain 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or L	ocation of Death 4c. County of Death
A		118 Limestone Road Hancock	Washington
Funeral Director		5. Social Security Number 212-50-9411 K M 2 F 6.1 6.1 6.1 6.1 6.1 6.2 6.2 6.3	If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) WV
ku a		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Aaryland 28a-f shuw 1 at once.	ō	WV Morgan Berkekey Spring	
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked after than "natural", or items 23a or 28a-f shi traumatic event, the Medical Examiner must be notified at once		59 Carriage Lane 25411 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hisp	us A anic Origin? (Specify Yes or No- 14, Race - American Indian, Black,
death v	Funeral		Mexican, Puerto Rican, etc.) White, etc.
s after ral", n	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	
2 hour:		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Decupation during most of working life. I	
21215-0036 uld be filed within 7 Mental Hygiene. marked uther than c event, the Medica	Completed	Brick Mason	Carpenter Construction
filed w Hygie duthe		17. Father's Name (First, Middle, Last)	B.Mother's Name (First, Middle, Maiden Surname)
Dealtiffillor, MD Z 1 Z 1 S -0050 Teamt. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked after than "natural", injury or other traumatic event, the Medical Examiner.	To Be	Virgil D. Cain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street	Frances J. Vangosen and Number or Rural Route Number, City or Town, State, Zip Code)
id 2 shoulth and is 27 is sumation	-		
s i and of Heal of Heal of then		20a. Method of Disposition 20b. Place of Disposition (Name of Cem 20c. Place of Disposition (Na	Lane Rerkeley SpringsWV 25411 etery, Date 20c. Location - City or Town, State WV
Dallillore, permit. Pages I as Department of He Important: If ite		4 Donation 5 Other Specify: Alpine U.M. Ceme	etery11/12/11 Berkeley Springs
permit Depart Impor injury		21. Signature of Funeral Service Licensee 22. Name and Address of South (Hunter-Anderson Funeral Hom
hysician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s	ch as cardiac or respiratory arrest, shock, or heart Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascula	Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of):	
	ЭĒ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last under the control of the contr	
and transit		d	
four ficate be exe physician the burial -	Medical	□ AMENDED 23a,27,per me,g923 1-9-	
LIVISION OF VICE RECORDS, F.O. BOX 60/00, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	23d. Date of delivery Ectopic pregnancy Month Day Year
death certific the attending ped for use as the	Physician/	Pregnant at time of death 5 Other (Specify)	
t the dea	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I. 23e. Did tobacco use contribute to the cause of death?
res that the signed by	d by		1 Yes 2 No 3 Probably 4 🗹 Unknown
Tecords, The law requir ficate has been s	Completed		24a. Was an 24b. Were autopsy findings available prior to completion of cause of
teco	E		performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ician: The certificate rector, page	Bec	examiner?	of Death (Check only one)
Lal or Attending Physician is after death. A Director: After this certi led in by the funeral directon	입	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA	at Work?
nding Pl th.	io.	(Month, Day, Year)	es 2 No
r Atte ter dea irecto n by th	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bu	
pital o	Certification:	4 Homicide determined (Specify)	or Town, State)
UNISION To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion,	
Tu th withi To th	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, of and manner stated. 29b. Signature and title of certifier 29c. License	
)		(listoma) o.c.m	
		30 Name and address of person who completed cause of death (Item 23a)	
N-0		Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street,	Baltimore, MD 21223
St Regis	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 38150 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8 Flizabeth Zear onrose Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Home and Village 17. Age My Washington Fahrney Keedy 9. Birthplace (State or Foreign Country) Mary Land vrs. last birthday If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, 1 □ M 2 F Hours Min 67 94 **Director** 213-42-1240 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c City Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Co. Boonsboro 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be i Funeral **USA** 8507 Mapleville Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Maryland 21215-0036 should be filed within 72 hours afti and Mental Hygiene. is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Donald R. Evler permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Betty J. Webber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristi A. Hull/ Daughter 2921 <u>Cathedral</u> Avenue, Hagerstown, Maryland 21742 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery Nov. 11, 2011 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Bignature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Fastern Blvd. N. Hagerstown MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final et and Death Physician/ ance disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical phys: Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) been signed by the atter should be detached for a in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death
Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 2 No 1 Yes Yes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 12 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dil 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and, address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Don Rose

egistrar's Signatu

11-08259	
Jessie Davis	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

SIC Davis		1- For State	State	or ivial ylariu /		tificate of		ilu Ment	ai Hygit		g. No.)	1 3815
Physici		1. Decedent's Name (Fi								ate of Death	1		3. Time of Death
dical Exami	iner	Jessie Dar 4a. Facility Name (if not		etreet and number\			b. City, Town,	or Location of		ovember	4, 2011 4c. County of		1115 hrs
		Gilchrist Hospid					Columbia	or Eocation of			Howard	Death	
Funeral Director		5. Social Security Numb	8 1_		92	ast birthday) Yrs.		ear If Under ays Hours	1	Date of Birtl		Foreign	nplace (State or W.Virginia ntry)
any		Usual Residence of Dec 10a, State 10b.	cedent County		10c. City,	Town or Location	on						10d. Inside City Limits
land f show	or		altimore	Э	На	lethorp	æ	_					1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 4818 Carmo		•			10f. Zip Code 21 2			10	g. Citizen of Wha	it Count	try?
death with or items 2	Funeral	11. Marital Status 1 Never Married			Ever in U. No	If Ye	s Decedent of I es, specify Cub	an, Mexican,			14. Race - White,	etc.	an Indian, Black,
rs after ural", miner	by	3 Widowed 4		If Yes, Give Yeer or Dates: y highest grade com	pleted)	16a. Decedent	Yes 2 X I		ind of work	done	Specify: 16b. Kind of Busi		ite
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First				Homemo	IIICI.				aiden Surname)		· · · · · · · · · · · · · · · · · · ·
121 Id be fil Aental Is narked event,	b Be	Charle 19a. Informant's Name/F	es Heate			10h Mailing	Address (St		mah Co		ber, City or Town,	Ctoto	Zin Code)
MD 2 id 2 shou lith and N m 27 is n	То	Larry A. D					Stoneh				tt City,		
ore, ss 1 and of Heal If item		20a. Method of Disposit	_	Removal from Sta	te C	Place of Disposi rematory or oth	ner place)		Dat		20c. Location - (
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other triping.		4 Donation 5 21. Signature of Funera			Lak	eview M	Mem. Pa:			2011	Sykesvi uneral H		•
Bal permi Depar Impo injur		21. Signature or Fulleta	VICELICENS	90			512 NW					207	
Physician /Medical		28a. Part I. Enter the ats failure. List only or	sease, or compli	cations that caused hine.	the death.	Do not enter th	ne mode of dyir	g, such es ca	rdiac or resp	oiratory erre	st, shock, or hear	t	Approximate Interval Between Onset and
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S876(rrtificate ling phys		IF FEMALE: 23b. Was decedent preg past 12 months?	nant in the	23c. If yes, outcom		2 Fet	tal death	B Ectopic	pregnancy		23d. Date of d Month	lelivery Da	ay Year
Box 68760, re death certificate be executed the attending physician and ted for use as the burial - transit	Physician/	1 Yes 2 ✔ No 9		4 Pregnant at 9 Unknown		3 Otr	ner (Specify)						
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	by	Part II. Other significar	nt conditions (contributing to death	but not re	esulting in the u	nderlying caus	e given in Par	rt I.				ne cause of death?
ords w requi as been s should	Completed	-							_ [24a. Was a autops	y pri	ior to co	opsy findings available empletion of cause of
Rec The la ficate h	Com	25.111		<u>.</u>							ned? de P. ✓ No 1 [eath? Yes	2 No
Vital hysicians this certi	o Be	25. Was case referred to examiner? 1 ✓ Yes 2	_	ospital: 1 Inpatie	nt 2	ER/Outpatient		Other4	Nursing Ho		Residence 6	Other:	Scene
ion of V tendiog Phy eath. ior: After th	Ξ:	27. Manner of Death	Pending	28a. Date of Inju (Month, Day Young 19, 2011	ry ear)	28b. Time of Ir 0000 hrs	njury 28c. Ir	njury at Work? Yes 2	Sub		ow injury occurred racturing hip	d	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification	2 Accident 3 Suicide 6 4 Homicide	Investigation Could not be determined	28e Place of Ini	-	ome, farm, stree	et, factory, office	e building, etc		or Town, St			al Route Number, City
To the Hosp within 24 hos To the Fune	cal	29a. Certifier 1 Cert	dical Examiner:	n: To the best of my On the basis of exam and manner stated.									
F & F S	Medi	29h Signature and title	of certifier	and manner stated.				nse number			29d. Date signed		
20		30. Name and address of	of person who	ompleted cause of de	eath (Item	23a)		C.M.E. ————			November 5	, 201	1
./0		Laron Locke Mi	D. Assista	ant Medical Exa	miner	900 W. Ba	Itimore Stre	eet, Baltim	ore, MD	21223			
S ⁱ Regis	tate trar	31. Date filed (Month O	V 0 9 20	11 32. Registrar	's Signatu	B. Sa	was						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 1 Physician/ Year 201 2126M Tricia Medical 4a. Facility Name (if not institution, give street and number, 4b. Çity, Town, or Location of Death **Examiner** Health BONNE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State & Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours (Month, Day, Year) 257-48-1487 1 □ M 2 ★ F Director 2, 1934 Georgia 76 28a-f show 10d. Inside City Limits 10c. City, Town or Location than "natural", or items 23a or 28a-f sho he Medical Examiner must be notified at Director 1 X Yes 2 No Prince George's Bowie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20715 3538 Madonna Lane 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🗓 No Specify Specify: White 3 ₩ Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Prince George's County Elementary/Secondary (0-12) College (1-4 or 5+) Cafeteria Manager 1+ Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Ethel Downs Herbert Patrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3538 Madonna Lane Bowie, MD 20715 <u>Lee Edward Dumais, Jr.</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 11/11/11 Clinton, MD 21. Signature of Funeral Service Lindosee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final entricular Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? nas autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 Yes ို 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day. Year) 11/5/2011 on who completed cause of death (Item 23a) (Type, Print) Center Prive 5001

Registrar DHMH 17 Rev 06-2011

State

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2:30A Eidsmore Medical Teresa M. ovante 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Srace If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 - M 2 X F 91 Months Days Hours Director 10/27/1920 Georgia Usual Residence of Deceder or 28a-f shov 10a. State death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Havre de Grace Harkord 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 306 <u>Heat</u>her Way 21078 S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Ves 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1943-45 other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainments. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Lee Hall Jewell E. Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Havre de Grace, Maryland 21078 Alan Eidsmore (Son) 306 Heather Way, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) & Co., Inc 11/17/2011 West Chester, PA we of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home. P.A. Washington St., Havre de Grace, MD 21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate the cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death detached Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 200 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No မ 1 🗌 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I Medical 29a. Certifier 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2" Medical Examiner: On the basis or examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

Hongs

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MOFE 5 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Deborah Ann Edner

		1- For State Registrar		Certificate	of Death			Reg. No. 201	<u> </u>
Physici ledical Exam		Debolair Bonel						Day Year er 15, 2011	3. Time of Death 1210 hrs
		4a. Facility Name (if not institution	give street and number) Court Unit C		4b. City, Town, Annapolis		f Death	4c. County of Death Anne Arundel	
Funeral Director			5. Sex 7. Age (In)	yrs. last birthday) 64 Y	If Under 1 Y Months D	ear If Under ays Hours	Min	/1947 Foreig	
any		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	ation		-		10d. Inside City Limits
.	ក		Arundel	Aı	nnapolis				1 XXYes 2 No
th the Maryland 23a or 28a-f sho netified at once.	Director	10e. Street and Number	O.T.		10f. Zip Code			10g. Citizen of What Cou	ntry?
death with the Maryland or items 23a or 28a-f shu must be notified at once	Funeral L	40 Amberstone 11. Marital Status	12. Was Decedent Ever		Vas Decedent of		in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - Amer White, etc.	ican Indian, Black,
her deat		1 Never Married 2 Mar 3 Widowed 4 XXDivo	1 Yes 2 XX	10	Yes 2 X 1		r dono man, day		ite
2 hours at "natural	ted by	15. Decedent's Education (Speci			ent's Usual Occu most of working I		ind of work done use retired)	16b. Kind of Business/	Industry
	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		Sa1	es		Retai	1
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica	Be Co	17. Father's Name (First, Middle, I Edward Ebner	.ast)				s Name (First, Middle, ion Burke	Maiden Surname)	
D 212 should be and Ment 7 is mark	To E	19a. Informant's Name/Relationsh				eet and Numb	oer or Rural Route Nu	mber, City or Town, State	, Zip Code)
ore, MC jes 1 and 2 s of Health an If item 27		David Ebner 20a. Method of Disposition	Brother 2	Ob. Place of Disp	osition (Name of		okhaven, N	Y 11719 20c. Location - City or	Town, State
Baltimore, bernit. Pages I at Department of Hee important: If ite		1 Burial 2 XXCremation 4 Donation 5 Other Spe		crematory or tlantic		rv	11/22/201	1 Glen Bur	nie, MD
Baltimo permit. Page Department o Important: injury or oth		21. Signature of Funeral Service I	icensee	22.	Name and Addre	ess of Facility	Hardesty F	uneral Home	, P.A.
Physician		23a. Part I. Enter the disease, or of failure. List only one cause of						rest, shock, or heart	Approximate Interval Between Onset and
iwecical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Mixed drug(0 Due to (or as a consequen		Amitri	ptyline	Doxepin)	Intoxicatio	D45
		Sequentially list conditions,	b						
	Examiner	If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or es a consequen c.						
scuted and transit		events resulting in death) Last	Due to (or as a consequen						
760, icate be executed physician and the burial - transit	Medical	X UNPENDED IF FEMALE:	AMENDED 23a, 27 Item 1, 4a-b,	,28a-f,per me,	3922 ^m 92 ^g	142112	-1-11 sm	Cood Bata of deliver	
	-	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	2 I		BEctopic	pregnancy	23d. Date of delivery Month) Day Year
that the death certificated by the attending detached for use as	Physician	1 Yes 2 No 9 V Unkn	own 9 Unknown	or death 5 (Other (Specify)				
- s 50 e	by	Part II. Other significant condition	ns contributing to death but r	not resulting in the	underlying caus	e given in Par		tobacco use contribute to es 2 No 3 Prot	
of Vital Records, P.C. ng Physician: The law requires that ther this certificate has been signed meral director, page 2 should be deter	Completed						24a. Was	psy prior to d	topsy findings available completion of cause of
Reco	Com						1 ✓ Yes	ormed? death? 2 No 1 Ye	es 2 No
/ital /sician: nis certi director	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatie			Check only one) Nursing Home 5	Residence 6 🗸 Other	: Scene
O B B B B B B B B B B B B B B B B B B B	-	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time o		jury at Work?	28d. Describe	how injury occurred	
Division tal or Attendi rs after death. al Director: A led in by the fu	fication	2 Accident Investi	gation Id II-I3-I		5/ pm	Yes 2 X I	. 28f. Location	t took medic	ral Route Number, City
Divis Hospital or A: 24 hours after c Funeral Directed filled in by	Certification:	4 Homicide determ		esidence			or Town, Annapol	State) 40 Ambers Lis, Md.	stone Ct.
the hir	Medical	Torrow City	rsician: To the best of my know Iner: On the basis of examination and manner stated.						
To with	Me	29b. Signature and title of certifier	and mariner stated.			nse number		29d. Date signed (Mod	
		30. Name and address of person w	ho completed cause of death (Item 23a)	0.0	C.M.E.		November 16, 20	лт —————
43		Carol Allan, MD Assi	stant Medical Examine	900 W. Ba	altimore Stree	et, Baltimoi	re, MD 21223		
St Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	all				

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Oscar	Arman	do F	lores
Jocai		uo i	10163

		1- For State Registrar		Cer	tificate d	of De	eath			R	eg. No.	· ·	. 0010
Physicia Medical Exami	ın/	1. Decedent's Name (First, Midd	. Decedent's Name (First, Middle,Last) 2. Date of Month								Day Yea	r	3. Time of Death 0834 hrs
LACTICAL EXAMIN	iici	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca								Novembe	r 16, 2011	of Death	
1		8040 Nancys Pond Court Pasadena								Anne Ar			
Funeral	_	5. Social Security Number	6. Sex 7. Age	(In yrs. la	ast birthday)	lf t	Under 1 Year	If Unde		8. Date of Bi	rth(MM/DD/YYYY	9. Birt	hplace (State or rEL Salvador
Director		216-61-7881	1 X M 2 F	37	Y	rs. Mo	onths Days	Hours	Min.	08/11	/1974		intry)
		Usual Residence of Decedent	-										
w any		10a. State 10b. County			Town or Loca								10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show d at once.	ğ		Arundel	F	Pasader				_				
e Many or 28ss	Director	10e. Street and Number	7				Zip Code				Og. Citizen of Wh		-
ith the		8040 Nancys Po			0 140 14		21122		:-0 / C	**-VN	El Sal		
ath w	Funeral	11. Marital Status 1 X Never Married 2 M	12. Was Decedent E Armed Forces?				cedent of Hispa becify Cuban, N				Vhite		can Indian, Black,
her de		3 Widowed 4 Div	vorced If Yes, Give Year	No	1 2	Yes	2 No	specify:	El Sa	alvado	rianspecify:	His	spanic
ours af	d b	15. Decedent's Education (Spe	or Dates: ecify only highest grade comp	oleted)			ual Occupation				16b. Kind of Bu	siness/lr	ndustry
6 72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 or 5-	+)	ŭ		working life. D	ONOL	use retired	3)			
within within Medi	틹	4			Cor	ıstr	uction				Comm		.al
215-0036 be filed within 7 rtal Hygiene. rked other than ent, the Medica	ပ္ခု	17. Father's Name (First, Middle Vernardino Bernildino	n, Last)				18				Maiden Surname)		
D 21215-00; should be filed with and Mental Hygiene 7 is marked other ti natic event, the Men	o Be	19a. Informant's Name/Relations			19b. Maili	ng Addi	ress (Street a		a Flo berorRun		nber, City or Tow	n, State.	Zip Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once.		Carlos Leveron	1 / Cousin		1508	3 Ar	undel 1	Rd.,	Edo	gewate	r, MD 2	1037	7
ore, ME ssland 2 si of Health ar If item 27 her trauma		20a. Method of Disposition			Place of Disponentation	osition ((Name of ceme	tery,	UNK (Date	20c. Location -	City or	Town, State
TOT Pages ent of rothe		1 Burial 2 Cremation 4 Donation 5 Other S		· .	Las F						Challata	i Na	nsection, ngo lor
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27	1	21. Signature of Funeral Service				_	and Address o	f Facility	Bea	all Fu	neral Ho		OL
E L L E		1/len			(5512	NW Cra	ain :	Hwy.	, Bow	ie, MD	2071	
Physician		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease condition resulting in death).	r complications that caused to on each line Acute s	he death. ubar	Do not enter	d he	de of dying, su morrha	ich as ca Re Wi	rdiacorro ith i	espiratory arı ntrav e	est, shock, or hea entricula	irt I T	Approximate Interval Between Onset and
Examiner	Ì	Immediate Cause (Final disease or condition resulting in death)	extension s	ebra	daryet	y ru	uptured	ane	urysı	n of th	e right		Death
			Due to (or as a consec	quence of	r):								
	힐	Sequentially tist conditions, if any, leading to immediate	Due to (or as a consec	quence of	f):								
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a consec	uence o	f\·							_	
uted d ansit		events resulting in death) Last	d.	derice of	.,.								
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8760, ificate be up physical street buri	Me	IF FEMALE:	23c. If yes, outcome	e of pregi	nancy						23d. Date of		
	ä	23b. Was decedent pregnant in the past 12 months?	he 1 Live birth 4 Pregnant at ti		oth		ath 3	Ectopic	pregnanc	У	Month	D	ay Year
Box 68 le death certi the attending	Physicia	1 Yes 2 No 9 Un	known 9 Unknown		5 □ (Other (Specify)						9
at the d by th		Part II. Other significant condi	tions contributing to death	but not re	esulting in the	underi	ying cause give	en in Par	t I.				he cause of death?
P.C. ires that signed I be deta	D D	Hypertensive	Atherosclero	tic (Carddio	vas	cular D)ise:	ıse,	1Ye	s 2 No 3	Prob	ably 4 VI Unknown
ords w requi	Completed by	Renal Calcul	i							24a. Was autor			opsy findings available ompletion of cause of
He lay	E									perfo		eath? ✔ Ye:	s 2 No
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the safer death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated.	Bec	25. Was case referred to medica examiner?	h				26.Place of	,					
Vit hysici this o	리	1 ✓ Yes 2 No	Hospital: 1 Inpatien		ER/Outpatier						Residence 6		Scene
J Of ling Pt After		27. Manner of Death 1 X Natural 5 Pen	28a. Date of Injury (Month, Day,Yea	/ ar)	28b. Time of	Injury	28c. Injury		- 1	8d. Describe	how injury occurre	ed	
Sion	Cati	_ J Fell	ding estigation	A4 h					-	26 1tim. /	Otenat and Newsba	a a a Door	al Davida Numb as City
Divis	Certification:	dete	ald not be 28e. Place of Injure (Specify)	iry - At no	ome, rarm, str	eet, rac	tory, office buil	aing, etc	. 20	or Town, S		r or Rur	al Route Number, City
Di lospital 4 hours a funeral l		29a. Certifier 1 Certifying P	Physician: To the best of my	knowled	ne death occ	urred at	t the time date	and pla	ce and du	ie to the caus	se(s) and manner	as state	d
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only	aminer:On the basis of exam										
T. is to	Σ	29b Signature and title of certific	and manner stated. er				29c. License r	number			29d. Date signe	d (Mon	th, Day, Year)
		Thed)	11 Kings.T.	0	4		O.C.M.	E.	OCA4F		November	17, 20	11
	-	30. Name and address of persor	who completed cause of de	ath (Item	23a)								
		Theodore M. King, Jr.				900	W. Baltimo	re Stre	et, Ball	timore, MI	D 21223		
St Regist		31. Date filed (Month, Day, Year)	32. Registrar	s Signatu	ire	ax							
		1101 2	- LUIII FRANK										
DHMH 17 Rev 1/20	701				ORIGINA	4L							

amend items 5,10e,20b per fh g928 6-8-12 vt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a &23PII Per PHY G922 12/21/2011 JH State of Maryland Department Health and Mental Hygiene Amend Items 23a per dr., g922 12/12/1016 Certificate of Death 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 9, Physician/ 201T 1:25 Roland Eric Florin -Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 324-05-2317 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) Hours 1 ૐM 2 □ F Director 96 Yrs. Jan. 18, 1915 IL 28a-f show 10d. Inside City Limits 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10a. State 10b. County with the Maryland **Funeral Director** 1 Yes 21 No Takoma Park MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 7407 7404 Cedar 10f. Zip Code USA 20912 Cedar Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 X Yes 2 No Black White etc. Specify: White 0 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Year or Dates. 1941-45 "natural" 3 Widowed 4 Divorced the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. College (1-4 or 5+) Elementary/Secondary (0-12) Government Research Chemist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၀ Gertha Augusta Schmidt Albert Eric Florin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3913 Chatham Road, Ellicott City, MD 21042 Suzanne Moran/Daughter 20b. Place of Disposition (Name of cemetery, crematory of other place)
Metropolitan Grematory 20c. Location - City or Town, State Nov. 11, 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State Alexandria, VA 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Cancer Approximate Interval Between Onset and Death Physician/ Due to (or as a consequence of): Failure Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine the buriaters To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ☐ Live Birth 2 ☐ Fetal deat☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Dementia, Failure to Thrive 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performed? 1 Yes 2 100 26. Place of Death (Check only one) To Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes 1 Depatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of injury Certificate: (Month, Day, Year) injury 1 Natural 5 \square Pending within 24 hours after death.

To the Funeral Director: Ai completely filled in by the fu Investigation 2 Accident
3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [29b. Signature and tille of certifier 29c. License number 11/09/2011 D-59284 1011 Asmin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID SHAMIM, HD WARHING TON ADVENTIST HOST, TALLOMA PARK, MD-20912

State

Registrar

31. Date filed (Month, Day, Year)

NOV 14

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Edward Graham 2011 7:45 AM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Citizens Harford Home Harve Grace NUrsina De 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** 6. Sex Age (In yrs. last birthday) 8. Date of Birth Hours Min. 1 👿 M 2 🗆 F 04-27-1940 220-34-7056 WESTYVirginia Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shor any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No |Maryland |Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States of America 368 Spring Hill Road 21911 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Armed Forces? Black, White, etc 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Year or Dates 1958-62 White 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Delivery Personel Logistics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward J. Graham Melva Marie Bolen 19a. Informant's Name/Relationship (Type, Print) Shelby Graham (Wife) 19b Mailing Address (Street and Number or Flural Poute Number, City or Town, State, Zip Code) 21911 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Harford Memorial Gdns: 11-17-2011 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Zellman Funeral Home, P.A. 22. Name and Address of Facility 123 S. Washington St, Havre de Grace, Maryland 23a. Part 1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ا 24 hours after death. Funeral Director. After this certificate has been signed by the attending physician and المعافرة المالية الما that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 g 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 Two 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death. autopsy perform 1 ☐ Yes 2 ☐ No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 16 Hospital: Other: မ 1 🗌 Yeş 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Mann of Death Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending injury 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer ess of person (Hem 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 0

Jame

arraham

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 a 9:05 а.м Marie Gazelle Nov. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Springhouse Westwood Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months (Month, Day, Ye April 16 1915 West Virginia Days Hours Min. **Director** 96 232-09-3352 Usual Residence of Decedent 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No Md. Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6415 Broad Street 20816 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1943-Black, White, etc. and 2 should be filed within 72 hours after or Health and Mental Hygiene. 1X Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Completed 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Statistical Clerk Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Gazelle Mary Barut 19a. Informant's Name/Relationship (Type, Pn'nt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Healtl Important: If item 2: Stanley A. Gazelle/Brother 6415 Broad Street, Bethesda, Maryland 20816 20b. Place of Disposition (Name of cemetery, crematery or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State N9811¹⁴, 4 Donation 5 Other (Specify) Silver Spring, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee DeVol Funeral Home M00215 2222 Wisconsin Ave. N.W. Washington, D.C. 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
I Year Immediate Cause (Final Physician/ disease or condition Congestive Heart Failure *Medical resulting in death) Due to (or as a consequence of) **Examiner** Heart Block 5 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed Hypertension 10 Years that initiated events ending physician ar resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 4 9 Unknown been signed by the should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed? Yes 2 K N death? 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes Assisted Living မ 2 🛚 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 7. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending s after death.

I Director: Aft
d in by the fur 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined n 24 hours after e Funeral Dire eleted filled in b City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examination On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiles: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s Certifying Nurse Practices: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated vithin 2. 3 🗆 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

NOV 14 20

Pasquale

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0053711

November 10, 2011

		1 - State Registrar 11/8/2011 AACO 1. Decedent's Name (First, Middle, Last)		Cel	rtificate of	Dealli	2. Date of Dea		3. Time of Death	
Physic		L. Susan Henderso					Month 11/4	4/2011 Year	948pm M	
/Medi Exami	·41	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of De		4c. County of Dea		
au . vm ant.	4	Anne Arundel Medi	cal Center			apolis		Anne Ar		
uneral irector		220 30 3137	7. Age (In yrs.		If Under 1 Year Months Days		Irs. 8. Date of Birth in. Month, Day 5/9/1	9. Bir 946 9. 60	thplace (State or Foreign ountry) MD	
>		Usual Residence of Decedent 10a. State 10b. County	10c, Ci	ty, Town or Lo	cation	<u>.</u>			10d. Inside City Limits	
f sho	0	,	1 1		1.				1 □Yes 🛣 📆 N	
r 28a- notif	Director	MD Anne Aru 10e. Street and Number	ndel	Ann	apolis 10f. Zip Code			10g. Citizen of What Co	ountry?	
23a o ist be	al D	2761 Gingerview L	ane		214	401		USA		
ems :	Funeral		12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)			
gene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	<u>ام</u>	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates:		1 □ Yes 2 ⊠ No	Specify:	,	Specify:	White	
n "natur fedical	Completed	15. Decedent's Educ (Specify only highest grade	e completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during most of i d)	working	16b. Kind of Business	/Industry	
the L	E O	Elementary/Secondary (0-12)	College (1-4or 5+) 4		Teacher			Educa	tion	
othe ent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	Name (First, Middle,			
marked o		Harold T. Evert				Lois	s Hoggard			
sum sum		19a. Informant's Name/Relationship (Type Melissa Henderson						er, City or Town, State,	,	
0 = =		20a. Method of Disposition 1 Burial 25 Cremation 3 R	20b.	Place of Dispo	edar Fall psition (Name of matory or other pla	i	Date	GA 3004 20c. Location - City or		
tant: If ite		4 □ Donation 5 □ Other (Specify)	A	tlanti	c Cremato	ory 1	1/9/2011	Glen Burni	e, MD	
Important; I any Injury o once,		21. Signature of Funetal Service License	ee				Hardesty I	Funeral Hom	ne, P.A.	
_ = @ O	\vdash	23a. art1 Ent r the lisease, or compli	141 Al4		2 Ridgel			s, MD 21401	Approximate	
ysician Medical aminer		sho k, or leart fillure. List only or Immediate Cause (Fir al diseast or condition resulting in de th) Sequentially list conditions, if any, leading to immediate	Due to (or as a consect.) Due to (or as a consect.)	quence of):	rdirvosci	Mar D	Heau		Onset and Death	
physician and s the burial-transil	dical Examine	Cause inter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d								
ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 21 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	y		23d. Date of de Month	elivery Day Year	
been signed by the s should be detached t	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
has Je 2	Completed	Deprussing 24a. Was an autopsy performer							y prior to completion of cause of death?	
certificate rector, pag	Be C	25. Was case referred to medical				26. Place of I	1□ Yes Death (Check only o		3 22110	
9 2	TO E	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatier	nt 3X DOA Oth	ner: Nurein	g Horne 5 ☐ Resid	dence 6 □Other (Spe	ecify)	
.s. ≒		27. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ryat rk?]Yes 2 ☐ No	28d. Describe h	now injury occurred		
ı. After this funeral dir		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	nome, farm, sti ify)	reet, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,	
tor: After this the funeral dir	Sertific			owledge, deat	th occurred at the tinvestigation, in my	ime, date and pl opinion, death o	lace, and due to the occurred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)	
tor: After this the funeral dir	dical Certification:	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my kn (ner: On the basis of examin and manner stated.	ation and/or ii						
tor: After this the funeral dir	Medical Certific	29a. Certifier (Check only one) 2 Medical Exami 29b. Signature and title of certifier	sician: To the best of my kn (ner: On the basis of examin and manner stated.	ation and/or ii	29c. Licens	se number		29d. Date signed (Mon	nth, Day, Year)	
ı. After this funeral dir		one)	sician: To the best of my kn (ner: On the basis of examin and manner stated.	auon ang/or n		se number 6 3 6 81		29d. Date signed (Mon	nth, Day, Year)	
tor: After this the funeral dir		one)	and manner stated.		200			29d. Date signed (Mon	nth, Day, Year)	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ NOVEMBER 5, 2011 Harold Donn Hooker 1700 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial TAUDOT HOSPITAL Easton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 81 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 539-28-4759 **Director** 1 💢 M 2 🗆 F July 19,1930 Washington Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland notified at Director Talbot MD Tilghman 1 X Yes 2 □ No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 5701 Leeward Lane 21671 USA 12. Was Decedent Ever in U.S. Armed Forces? **Korean** 1 Yes 2 No War Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: White Specify. 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Foreign Service Officer Department of State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H 7 is marked of ၉ Clarence Hooker Clara Busch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trac 8308 Quill Point Drive Bowie, MD 20720 Richard Berg/ Son-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Nov. 001 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Far ral Service Licensee CREMATION DIRECT 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ rdores disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury -transit the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last been signed by the attending physician Completed by Physician/Medical the wran Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? artery direau Sp CABG 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 Yes 2 No Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital Other: ြင 1 Yes 1 The patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation after death Accident 2 LAccident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral L Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Teklemic

D72893

MD 219 S. Washington Street Easton, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Physician/ November 0607M Vancy Corrine Hawbecker 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Meritus Medical Hagerstown Washington enter If Under 1 Year If Under 24 Hrs.

Davs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) M D 1 .M 2 X F 07/24/ 217-30-6245 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Clear Spring 1 🗆 Yes 2 🗙 No Washington MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 14824 Hicksville 21722 Koad Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bruce Bowers Bernice Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) onnie Michael 11018 Big Pool Road daughter) Pool Big 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, 4 ☐ Donation 5 ☐ Other (Specify) edar Cem. III 2011 awn 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc.
Donald Edwin Olean Spring, MD 21722 Donald Edwin P.O. Box 310 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death signed by the a d be detached for 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has completed filled in by the funeral director, page 24. autopsy performed? Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No 1 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 162588 11-14-2011 address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Mon

1116 Medical Campus

Road, Hagerston M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 14, 2011 9:20 Physician/ **P** M Jackie Lee Harp Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 13311C Hunter Hill Drive Hagerstown 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** (Month, Day, Min Days 1 🕅 M 2 🗆 F 1940 71 Maryland Director 218-34-2841 Usual Residence of Decedent 28a-f show 10d Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10c. City, Town or Location 10a. State Director 1 Yes 2 No MD Hagerstown Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 13311C Hunter Hill Drive 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. þ 1 ☐ Never Married 2 🔀 Married 1 X Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15 Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Home Improvement Handyman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rosezella May Chapman Edward A. Harp, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13311C Hunter Hill Drive, Hagerstown, MD Mary C. Harp/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 11/16/2011 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Mull 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myscardial Physician/ minutes Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence off. Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 4 Pregnant : 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 diabetes, hyporlipidemin 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this funeral 28c. Injury at Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Natural 🖳 1 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 14/201

State Registrar

TW-VE+

Hagerstown,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 5:40P.M 2011 Catherine May ISEMINGER 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Boonsboro Reeders Memorial Home Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y 1 □ M 2 🛣 F Months Days Hours Min. Mary Land 82 Yrs 214-28-0579 June Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits tX Yes 2 □ No Marvland Washington Funkstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21734 E. Cemetery Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Post Office 12 0 Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Susan Huffer Frank Earl Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21734 Alfred Larry Iseminger - Son P.O. Box 485, Funkstown, Md. 7 E. Cemetery St. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/15/2011 Funkstown, Maryland Funkstown Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final PRUBABL PNEUMON disease or condition resulting in death) WEE Due to (or as a consequence of) USSARUCTIVE PULMONARY YRS hloric Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): DISEASE that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day g cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 75~500~ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician/ Medical **Examiner** Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed

Important: If item 27 is any injury or other tra once.

Department of

Physician/

Medical

10a. State

Examiner

Funeral

Director

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2 should be filed within 72 hours. In and Mental Hygiene. It is marked other than "natura traumatic event, the Medical Estraumatic event, the Medical Estraumatic event.

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Division of Vital Records, P.O. Box 68760

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Certificate:

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II. Other significant condition	s contributing to death but not	resulting in the underlying
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	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital
illoare.	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a
	2 Accident Investigatio 3 Suicide 6 Could not b	
-	4 Homicide determined	200

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pital:	1 Inpatient 2	ER/Outpatient	з 🗆 І	DOA	Other: 4	Nursing H	ome	5 Residence	6 Other
	Date of injury (Month, Day, Year)	28b. Time of injury	М	28c.	Injury at work?			Describe how inju	
28e.	Place of Injury - At ho	me, farm, street	t, facto	ory, of	fice		28f.	Location (Street a	and Number

D0018019

1 ☐ Yes 2 ☐ No		
ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)	

Other (Specify)

2011

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29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
(Check	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
only one)	ne) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29h. Signature a	nd title of certifier		29c. License number		29H Date signed (Month, Day, Year)						

			_						
30. Name and	address of	person	who	completed	cause	of death	(Item 23a)	(Type,	Print)

9 3

MARYLAND	21740	301-739-7100

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after death.

Director: Aft d in by the fur

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ${\tt Novembe}^{\tt Day}$ 3 2011 Mildred Johns 1233 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Glen Burnie Anne Arundel Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Mayth, 26 Year 948 Maryland **Director** 214-54-8011 63 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Severn 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8209 Averill Ct. 21144 USA 12, Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 🕅 No
If Yes, Give
Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify "natural", Specify. **Black** 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 Nursing Assistant Genesis Elder Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked any injury or other traumatic eventoe. မ Unobtainable Elzen Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Johns (Husband) 8209 Averill Ct. Severn, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Maryland Veteran 11-10-11 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mmame are see of ScillisSons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Arres disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Stage I with liver of lung Motastasis Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work' 1 Yes 2 🗌 No Accident Investigation 24 hours after death Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 Certifying Nurse Practioner: To the best of my knowledge, de only one oth consisted at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) G8017 04/2011

Registrar

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Highway

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Middleton

32. Registrar's Signature

Rebecca

NOV 082011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day GUY LINCOLM KEEFER Nov Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sharon Acres Road Forest Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Bay, Year 48 Days 1**X** M 2 □ F Months Hours Min 215-54-1698 **Director** 63 Yrs. Waryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD. Harford Forest Hill 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral with 23a 1434 Sharon Acres Road 21050 United States items 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedon 2. Armed Forces?

1 ☐ Yes 2 No Black, White, etc. ٥ þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. "natural" 3 Widowed 4 X Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Printer Box Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Guy Keefer Samuel. Madine Loretta Woodring Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) Sister-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21162 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau <u>Stella</u> L. Mihavetz/in-law 5622 Carrington Drive Marsh White 20a. Method of Disposition 20b. Place of Disposition (Name of Nov. 17, 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Mem Gardens Air. Maryland 21. Signature of Funeral Service Irio 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville. Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknows Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? certificate has page 2 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of De th 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1/1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie

State Registrar 9

30. Name and address of person

10

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38166 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Arthur Masaaki Kaneko , 2011 November 8 1:25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3705 Randolph Road Silver Spring Montgomery Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 554-10-7251 Hours Director 1 XM 2 F 99 Yrs. Oct. 27, 1912 CA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3705 Randolph Road 20902 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Completed by Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2 X No Specify: 3[™] Widowed 4 □ Divorced Specify: Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Central Intelligence College (1-4 or 5+) Research Analyst Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Yoshio Kaneko Chiye Nagasi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vickie Kaneko/Daughter 3928 Rolling Road, Pikesville, MD 21208 20b. Place of Disposition (Name of 20c. Location - City or Town, State Arlington National 1 X Burial 2 Cremation 3 Removal from State n. 31, 2012 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Arlington, VA 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that cause othe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. resulting in death) Last Due to (or as a consequence of): the attending physician thed for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Diabetes, Prostate Cancer, Edema 1 Yes 2 X No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed⁴ 2 🗌 No 1 Yes Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: ္ဝ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 24 hours after death.

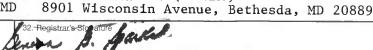
To the Funeral Director: After this certificate h

124

Scott P. Hopkins, MD 31. Date filed (Month, Day, Year, NOV 14 2011 Registrar

29a. Certifier

only one) 29b. Signature and title of certifie



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (WRNMMC)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

VA 0101247

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Növember Бау 4. 201T 9:48 Violet Arbutus Kemp Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 947 Chestnut Street <u>Washington County</u> Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min Mary Land 1 M 2 F 213-18-8486 88 Yrs Director Jan. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other transmission. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Maryland Washington Co. Hagerstown NO Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 947 Chestnut Street 21740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: Specify: White Completed 3 ¥ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hosiery Mfg. Knitter 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harlan Thomas Harr Katie Virginia Kreglo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye 1. Stottlemyer / Daughter 14536 National Pike, Clear Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State matory or other place) 1 💢 Burial 2 🗌 Cremation 3 🔲 Removal from State Rose Hill Cemetery Nov. 8,2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Si nature of Funeral Service Chee 22. Name and Address of Facility Douglas A. Fiery Funeral Home Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Ph sician/ Cancer 0 Years disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Securities y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 🔲 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numb 11/11/2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type,

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (M

MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per verb., g921,11/30/2011dhb Certificate of Death Reg. No. 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mov 15, 2011 Physician/ 8:20 AM M Llewellyn Frances Margaret Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Rawlings 23665 McMullen Hwy. SW g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Country WV **Funeral** Hours Months Jun 14. 90 **Director** 220-10-4943 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Rawlings notified MD Allegany 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ö must be Funeral USA 21557 15601 Skipton Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. o, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: white "natural" Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Celanese Co coning department Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Delphia Bean Charles Henry Shadwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23665 McMullen Hwy. SW Rawlings MD 21557 19a. Informant's Name/Relationship (Type, Print) Phyllis Ward daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Restlawn Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State MD 11-19-201 LaVale 4 Donation 5 Other (Specify) ignatur of Funeral Serv 22. Name ar Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_ician/ ementia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure Completed by 2 No 3 Probably 4 Unknown 1 Yes within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Dursing Home 5 Residence 6X Other (Specify) residence 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Tes မြ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injurv 1 🔀 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifie Medical H0056080 16 Director

Registrar
DHMH 17 Rev 7/2009

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17204 McMullen Huy S.W. Cumberland MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Day, Year)

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31. Date filed (Month

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32. Registrar's Signature

md 20211 Lopez, Jorge 11/10/11

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29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of entifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babak S. Pirouz, MD 8600 Old Georgetown Road, Bethesda, MD 20814	4eco	he law r te has b age 2 sl	omple							auto perl	opsy formed?	prio dea	or to completion of cause of the		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38170 Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ November 2 0131 5:10AM 201 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Itmore Pkins HO(P a If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Security Number 6. Sex Year **Funeral** (Month, Day, Year) Months Days Hours Min 551-88-0115 59 **Director** XX M 2 D F 10/16/1952 MN items 23a or 28a-f show her must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2XXNo MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 505 Ridge RD. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. an "natural", or iter Medical Examiner Armed Forces? Black, White, etc. 1 ☐ Never Married 🏖 😾 Married ģ Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 XXo Specify. Completed 3 Widowed 4 Divorced Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Church Pastor event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Eugene A. Mobley Wanda Yolanda Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, MD 21401 Susan A. Mobley Wife 505 Ridge RD. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial XX Cremation 3 Removal from State cemetery, crematory or other place) 11/6/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory . Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Jaki Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ardionu disease or condition Medical resulting in death) **Examiner** chiseruse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
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1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 \(\frac{\lambda}{\text{N}}\) No within 24 hours after death.

To the Funeral Director: After this certificate To the Hospital or Attending Physician: within 24 hours after death. funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes 2 💢 No 2 1 🕻 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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Registrar

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Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items10a-f per inf 9924 2-15-12
State of Maryland / Department of Health and Mental Hygiene 20 | | 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) MOFFETT GILBERT 07:32 AM Physician/ CHOMYA 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death 4b. **Examiner** Baltimore Hopkins HOSDITA Johns If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) (Month, Day, Year) 2/15/1921 **Funeral** Min Washington DC **Director** 1 ▼ M 2 □ F 577-28-2486 90 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location State notified at Director Barefoot Bay Florida **Brevard** 1 X Yes 2 XINO MD ecil10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ō 1106 Sabal Palm Lane 32976 ed other than "natural", or items 23a or event, the Medical Examiner must be in Funeral U.S.A. 21921 permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?
1 XYes 2 □ No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give Completed 3X Widowed 4 □ Divorced Year or Dates. 1944-1945 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Commercial al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Airline Pilot Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H
If item 27 is marked ot
ir other traumatic ever 2 Harvey Moffett Margaret Blinco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Health Crossan Court, Landenberg, PA 19350 Robert H. Moffett - Son 6 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/12/11 Leesburg, VA Union Cemetery 21. Signature of Funeral Serv 22. Name and Address of Facility Loudoun Funeral Chapel VA 20175 Catoctin Cr. SE, Leesburg. 158 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METASTATI Immediate Cause (Final disease or condition LUNG CANCER Plu i ian/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentian, list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) and that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of) attending physician for use as the buris Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy page 2 s performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 은 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work? 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Medical Certificate: within 24 hours after death.

To the Funeral Director: After of the funer of the fu Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one the 29d. Date signed (Month, Day, Year) 29b. Signa RES -000 (Item 23a) (Type, Print) 600 N. WOIFEST, Baltimore MD 21287 30. Name and address of person who completed cause of death, 0 AHON Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 12:15A M 2011 November JANE TOMLINSON MORAN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Laytonsville 8112 Whirlwind Court If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 509-40-2733 1 □ M 2 🛛 F **Director** Dec. 22 1937 Missouri 73 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State with the Maryland ms 23a or 28a-f sho must be notified at Director Laytonsville 1 Yes 2 X No Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20882 Funeral United States 8112 Whirlwind Court Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11. Marital Status er than "natural", or ite the Medical Examiner Black, White, etc. Armed Forces 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) U. S. Government Executive Administrator permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Harris ပ္ Jenny Henry Tomlinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 8112 Whirlwind Court, Laytonsville, MD Alexandra H. Langley/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State Alexandria, Virginia Metropolitan Crem. 11/07/11 4 Donation 5 Other (Specify) Muriel H. Barber Funeral Home 22. Name and Address of Facility 21. Signatur of Fune al Service Lenses 20882 Laytonsville, MD P.O. Box 5038, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Day Immediate Cause (Final Myocardial Infarction Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ending physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ģ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death been signed by the a should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No cate has I; page 2 s 1 Yes 2 No certificate 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Cther (Specify) Hospital: 1 ☐ Yes 2 🗷 No 0 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after deaun.

To the Funeral Director, After 1 1 X Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifler November 7, 2011 D 0055694

DHMH 17 Rev 06-2011

Registrar

4000 Olney-Laytonsville Rd.,

arks

20832

Olney, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Alok Mathur, M.D.

8

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death T1, 2011 November 5:20 aM 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) D.C. March 9, 1949 10d. Inside City Limits 1 🗆 Yes 2 🌁 No 10g. Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc White 1 ☐ Yes 2 KNo Specify: Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Surname) Betty Jane Lloyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14506 Manor Park Drive, Rockville, MD 20853 Date 20c. Location - City or Town, State 14, Noxi Gate of Heaven Cemetery Silver Spring, MD Francis Adgess Collins Funeral Home Inc. 23a. Part 1. Enter the deedse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Dav 23e. Did tobacco use contribute to the cause of death? 1 XXYes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Yes 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred work?
1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60634 Nov. 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph, MD 1355 Piccard Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) Registrar's Signature NOV 14 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	in the past 12 months? I Live Birth 2 Li Fetal death 3 Li Ectopic pregnancy										ite of del	e of delivery nth Day Year							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Physician/ McCoy Arline Μ. Nov. 2011 11:48P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Candle Light Cove Assisted Living Easton Talbot Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min 1 □ M 2 🗶 F Hours Indiana 10/1/1920 579-16-7555 Director 91 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Queen Anne Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Ashley Drive Funeral 21617 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Teamsters Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Murken Louis F. Detlefs Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Judy M. Welton/Daughter</u> 108 Ashley Drive, Centreville, MD 21617 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 11/12/2011 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility $\ensuremath{\text{George}}\ P$. Kalas Funeral Home 5160 Oxon Hill Rd. Oxon Hill, MD 20745 Part 1. Euler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FAILUVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner month Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Years and the attending physician and for use as the burial-Physician/Medical Box 68760 23b. Was decedent pregnant Live Birth 2 Fetal death 23d. Date of deliven 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 No Month Day Year Pregnant at time of death signed by the a Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulti*n*g in the underlyi*n*g cause give*n in* Part I. 23e. Did tobacco use contribute to the cause of death? by 2. No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has lirector, page 2 s autopsy performed? Yes 2 No 1 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 15515760 1 🗌 Yes 2 🔀 No Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp. this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 7/2009

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32. R

Du #101 Easton, Mc 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend#31 per HD State of Maryland / Department of Health and Mental Hygiene - State Registrar AACO Health Dept. Certificate of Death 11-8-11_KAH 2. Date of Death 1. Decedent's Name (First, Middle, Last) 05:00 P M Bay No∜ember 20 TT Physician/ William Wesley Neall, Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Arnold 600 Belle Dora Court Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 219-38-1934 1 🛚 M 2 □ F Maryland Director 12/27/1941 69 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State Director must be notified 1 Tes 2 X No Anne Arundel Arnold Marvland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ō United States 23a 21012 600 Belle Dora Court items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status rmed Forces?
A Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or þ 1 ☐ Yes 2 X No Specify. within 72 hours after Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates.Vietnam 3 Widowed 4 X Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Store Owner Self Employed permit. Page 1 and 2 should be filed win Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, the once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris McGinnis |William Wesley Neall, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)
Michael S. Neall/Son 1024 Deep Creek Avenue, Arnold, Maryland 21012 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State All Hallows Cemetery | 11/9/2011 Davidsonville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Lu 2973 Solomons Island Road, Edgewater, MD 21037 Rart 1. 5 fter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronau disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy After this certificate has perform 1 Yes 2 No 1 Yes 2 No nin 24 hours after death.

the Funeral Director: After this certifical pletely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{K}\)Residence 6 \(\sum \) Other (Specify) 2 **X**No 1 Inpatient 2 ER/Outpatient 3 IDOA 1 Yes ျ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 In Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title November 7, 2011 D50605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Elliott Christie, 2661 Riva Road, Suite 610, Annapolis, Maryland 21401 31. Date filed (Month, Day, Year) State 7NOV 082011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Loretta Ostroff 12:50a M Novembe. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Hebrew Home of Greater Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🗓 F Months Days Hours Pennsulvania Director 93 179-03-7486 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Rockville Maruland Montaomeru 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? by Funeral 20852 U.S.A. 6121 Montrose Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give "natural", White Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important if iten 27 is marked other the any injury or other traumatic event, the I once. 12 Clothina Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Max Cohen Ellen (Unknown) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Ostroff - Son 14447 Stonebridge View Dr., N. Potomac, Maryland20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 11/13/2011 | Trevose, Pennsylvania Bonation 5 Other (Specify) Roosevelt Mem. Park gnaty e of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, M0070 11800 New Hampshire Ave., Silver Spring,MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/ No 3 Probably 4 Unknown 1 Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28c Injury at 28d. Describe how injury occurred Watural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death Completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d) Date signed (Month, Day, Year,

Registrar
DHMH 17 Rev 7/2009

State

(ROSE RI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 14 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ George Paleologo 12:32AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 04 Baltimore Maryland Med Ctr 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 213-42-7247 **Director** 1 **X** M 2 \square F Yrs 67 June 19.1944 Washington, DC Usual Residence of Decedent show 10a. State 10c. City, Town or Location with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. Count 10d. Inside City Limits Director 1 Yes 2 X No Maryland Laurel Prince George's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 14054 Vista Drive, #58A 20707 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Architect Construction 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Athena Eldis Robert Paleologos Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chryssa Wolfe - Sister 4927 Eskridge Terrace, NW, Washington, DC 20016 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 11/11/2011 Baltimore, Maryland permit. 21. Signature of Funeral Service Licens MOISGO 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ card 40 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) an and The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician a use as the burial Physician/Medical Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) 3 for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the at Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 WNO မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After 1 Natural 5 Pending work? 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: A Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/8/2011 mD Resident Physicia

State Registrar Greene

32. Registrar's Signature

Ba Himore

MD

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shenderov

NOV 14 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a & 27 per med cert G922 12/6/11 dk.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Physician/ \mathbf{p}^{M} 2011 Nov. Martha Irene PRICE Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Williamsport Nursing Home Williamsport Washington 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex **Funeral** Country)
Maryland Hours Sept. 80 Director 16 213-50-9347 Usual Residence of Deceden 10d. Inside City Limits 28a-f show 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Williamsport Washington 10g. Citizen of What Country? 10e. Street and Number Funeral USA 16505 Virginia Avenue C-33 21795 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White If Yes Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry nd Mental Hygiene, marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Her own home Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, I once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bernard Barnhart Viola Corderman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16505 Virginia Avenue, C-33, Williamsport, Md. William H. Price - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Broadfording Ch. Cem. 11/12/2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Minnich Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Robert 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ ACUTE MYOLARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Pulmonary Edema Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed tran Due to (or as a consequence of): the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day Other (specify) Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Tes 2 No 3 Probably 4 Unknown SENILE BEMENTIA page 2 should 24b. Were autopsy findings available 24a. Was an performed 1 ☐ Yes 2 ☐ No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? iniury 1 K Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 33 1105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ST.

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31. Date filed (Mo

WILLIAMSPORT MET MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 10:30 A M David C. Ryan, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Fairfield Nursing and Rehabilitation Crownsville Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number . Age (In vrs. last birthday) **Funeral** Months Days Hours 9/4/1929 82 Yrs. Panama 436-52-3735 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State must be notified at with the Maryland Director 1 Yes 2 No Annapolis MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? ö 10e, Street and Number Funeral items 23a USA 21401 1027 Mastline Dr Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hyglene. tant: If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1948 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1952 Yes 2 No Specify: Panamanian White 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Transportation Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Reeves David C. Ryan, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vilma Ryan / Wife 1027 Mastline Dr., Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State injury or permit. Page Department of Important: If any Injury or 11/8/2011 Edgewater, MD 4 Donation 5 Other (Specify) Crematory Kalas 22. Name and Address of Facility George P. Kalas Funeral Home Funer I Ser Signan e Licensee 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Se wentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a conseque To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) 9 | Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 ☐ No 3 ☐ Probably 4 🞾 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) 2 X No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) s after death.
al Director: After th 28c. Injury at work?
1 \square Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injurv Natural Accider 5 Pending 2 🗌 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tit 29c. License number 2106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

32. Registrar's Signature

8

11-08263 Ralph E. Roles Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physicia	an/	Registrar 1. Decedent's Name (First, Middle						2. Date of Deat	h	3. Time of Death
^-dical Exami	ner	Ralph E. 4a. Facility Name (if not institution		r)		City. Town. o	r Location of Deat	Month November	4, 2011 4c. County of Deatl	1313 hrs
1		7026 Carroll Avenue #		',		Takoma Pa			Montgomery	
Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. las	st birthday)	If Under 1 Yes			h(MM/DD/YYYY) 9. Bii Forei	an
Director		201-32-9471	1XM 2F		67 Yrs.	Working	ys riodis itili	Dec. 1	14, 1943 c	untry) PA
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Location	1				10d. Inside City Limits
	5	MD Monts	gomery	T	akoma P	ark				1 X Yes 2 No
Maryla	Director	10e. Street and Number		".0		10f. Zip Code	10	10	og. Citizen of What Cou	ntry?
15-0036 filed within 72 hours after death with the Maryland I Hygiene. ed other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once.		7026 Carro11 A	Ave., Apt.		12 Was	209	91.∠ ispanic Origin? (S	Specify Yes or No.	USA	ican Indian, Black,
eath w	Funeral		Armed Force				in, Mexican, Puerto		White, etc.	iodi ilidai, blast,
after d	Ų		orced If Yes, Give Year or Dates:			es 2 X No			Specify: Whi	
hours "natui	ted	15. Decedent's Education (Special Elementary/Secondary (0-12)	cify only highest grade of College (1-4 o				ation (Give kind of e. DO NOT use re		16b. Kind of Business/	Industry
036 thin 72 ne.	Completed	12	Joney (1 1 o		Accou	ntant			Accounti	ng
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c		17. Father's Name (First, Middle,			-			e (First, Middle, N	faiden Surname)	
12 d be lents	o Be	Kaymond 19a. Informant's Name/Relationsh	J. Roles		19b. Mailing /	Address (Stre		n Shope Rural Route Num	ber, City or Town, State	, Zip Code)
MD id 2 shoulth and I is a 27 is 18 and a matric	۲	Donna L. Mille							eencastle,	PA 17225
	ı	20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from S		lace of Dispositi ematory or othe O Reste		emetery,	Date 17,	20c. Location - City or	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Sp	ecify:	ATE	emeterv		20)11	Altoona,	
Ball permit Depart Impor injury		21. Signature of Funeral Service I	T			me and Addres	111		Fries Funer burg, PA 1	al Home Inc
Physician	\dashv	23a. Part I. Enter the disease, or		d the death.	Do not enter the	mode of dying	g, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease								Death
and the second		or condition resulting in death)	Due to (or as a con	sequence of)	:					
	ner	Sequentially list conditions, if any, leading to immediate cause. Find the drying Cause	Due to (or as a con	sequence of)	i.					
Į.	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of)	-					1
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: 68760, certificate be executed mding physician and use as the burial - trans	Medical	UNPENDED IF FEMALE:	AMENDED						23d. Date of deliver	<u> </u>
K 6876 n certificat ending phy use as the	an/M	23b. Was decedent pregnant in the past 12 months?	I Trive pirm		2 Feta	I death 3	Ectopic pregn	nancy		y Day Year
	Physician/		nown 9 Unknown	at time of dea	th 5 Othe	(Specify)				
		Part II. Other significant condition		ath but not res	sulting in the un	derlying cause	given in Part I.		bacco use contribute to	
s, P.O. uires that th signed by d be detach	ed by								2 No 3 ✔ Pro	
cords law requi	plet							24a. Was a autop perfor	sy prior to	topsy findings available completion of cause of
	Completed						(0. 1. (0)	1 ✔ Yes		es 2 No
of Vital ig Physician: .fter this certifi neral director,	e Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	(Hespital:	ient 2 E	ER/Outpatient		Other Nursi		Residence 6 🗸 Othe	r: Scene
		27. Manner of Death	28a. Date of Ir (Month, Day	ijury ,Year)	28b. Time of Inj	ury 28c. Inji	ury at Work?	28d. Describe h	now injury occurred	
sion ttendi death. ctor: /	atio	1 Natural 5 Pend 2 Accident Inves	ling stigation				Yes 2 No			
Division pital or Attendi ours after death. eral Director: /	Certification	deter	d not be 28e. Place of (Specify)	Injury - At hor	me, farm, street,	factory, office	building, etc.	28f. Location (S or Town, S		ural Route Number, City
Hospital 24 hours : Funcral etely filled	I	4 Homicide 29a. Certifier 1 Certifying Ph	nysician: To the best of	my knowledge	e, death occurre	d at the time, o	date and place, an	d due to the caus	e(s) and manner as sta	ed.
Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medica	one) 2 Medical Exar	miner: On the basis of ex and manner state	amination an	d/or investigatio			at the time, date		
	Σ	29b. Signature and title of certifier	r / /				.M.E.		29d. Date signed (Mo	
K		30. Name and address of person	who completed cause of	death (Item 1	23a)	0.0			14040111001 0, 20	
10		Pamela E. Southall, M	ID Assistant Me			W. Baltimo	re St re et, Balt	timore, MD 2	1223	
	ate	31. Date filed (Month, Day, Year)	2011 32. Regist	ar's Signatur) por	Ch.A.				
Regist	TET.	a feet to want to	Market Lands	10	- P					

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State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Cer	tificate of L	Death	R	eg. No.			
i.	Physicia Medic		1. Decedent's Name (First, Middle, Last) Elizabeth Gaynelle Stallings				2. Date of Deat		20 7 1	3. Time of Death 9:00 A M	
-	Examin		4a. Facility Name (if not institution, give street and number) 768–F Fairview Avenue			r Location of Death napolis			y of Death	rundel	
As a	Funeral Director		5. Social Security Number 576–36–6245 6. Sex 1 ☐ M 2 ☒ F 74	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9/16/1	Year) 937	Count	lace (State or Foreign ry) Virginia	
	ryland I-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Maryland Anne Arundel	Town or Loc		napolis	L		11	0d. Inside City Limits	
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 768-F Fairview Avenue		10f. Zip Code	21403		l 0g. Citizen of	What Count	1 🙀 Yes 2 □ No try?		
	by	11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates.	- 1	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spa an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac	ce - America	an Indian,		
Baltimore, Maryland 21215-0036	thin 72 hou ane. than "natu ne Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Honemaker Own						lustry Home	
land 2	be filed wi ental Hygie ked other ic event, ti	To Be (17. Father's Name (First, Middle, Last) Archie M. Wild			18. Mother's Nam	e (First, Middle, N da Presl			Tionic .	
, Mary	d 2 should alth and M 1 27 is mar er traumat		19a. Informant's Name/Relationship (Type, Print) Melvin Brooks Stallings/spouse			and Number or Rura W Avenue					
ımore	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to		1 X Burial 2 Cremation 3 Personal from State Cen	netery, crem	sition (Name of natory or other place Mem. Gal	rdens 11/		20c. Location Annapo	•	wn, State Maryland	
Balt	permit. Departn Importa any inju		21. Sign and of Fundal Pervice Ligensee			ss of Facility Joh f Glouces					
	Ph _{sician/} Medical		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (as a consequer	g, such as cardiac o	or respiratory arre	st,		Approximate Interval Between Onset and Death			
	Examiner	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	nes on.							
	tificate be executed ng physician and s as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent)	nce of):					+		
8/60	ficate b g physicas the b	Medical	d								
g XOX	death cert le attendir ed for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnanc 1 ☐ Live Birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3	Ectopic pregnand Other (specify)	су			ate of delive	ory Day Year	
IS, P.O.	uires that the signed by all de deta	þ	Part II. Other significant conditions contributing to death but not result Metastatic breast Ca	ting in the ur	, ,	ven in Part I.		id tobacco use contribute to the cause of death?			
or Vital Records,	he law req ite has bee bage 2 sho	Completed					24a. Was an autops perform	ned?		osy findings available inpletion of cause of	
Ital	sician: certifica lirector,	Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 E		Oth	ace of Death (Checker:	only one)				
n or v	iding Phy th. : After this e funeral d	cate: To	T inpatient 2 L Er	R/Outpatien 8b. Time of injury	28c. Injur work	y at	me 5 K Reside 28d. Describe ho				
UNISION	al or Atter s after dea al Director ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (St. City or Town		t and Number or Rural Route Number, tate)		
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination a 3 Certifying Nurse Practitioner: To the best of my	and/or investi	igation, in my opinion death occurred at the	on, death occurred a the time, date and pla	the time, date an	d place, and du	e to the cau	se(s) and manner stated.	
	To To To to		29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signe	ed (Month, E	Jay, Year)	
	56		30. Name and address of person who completed cause of death (Item 2:			Hickory	2./	Arnold	nu.	D 21012	
Ī	Stat Registra	_	31. Date filed (Month, Day, Year) 8 2011 32. Registrar's Signatur	_	and		7		/	5/0/2	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary K. Samaras November 9:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis 925 Bay Ridge Rd. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Hours **Director** 232-44-1104 1 □ M 2 🗓 F Yrs. 10/28/1927 West Virginia 84 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director 1 🗆 Yes 2 🖁 No Maryland | Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21403 925 Bay Ridge Rd. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 2 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Liquor Store Owner Be 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H
Important: If item 27 is marked oth any injury or other transpace 17. Father's Name (First, Middle, Last) Evangeline Koungoulos Nicholas G. Kambouris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 61 East Lake Drive, Annapolis, Maryland 21403 Stephen C. Samaras/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Demetrios Cem. 11/11/11 Annapolis, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur of Junery S. Mus 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s autopsy has I ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: ours after death.

eral Director: After this certificatile in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 Tyes 2 40 1 Inpatient 2 ER/Outpatient 3 IDOA 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner ath 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Certificate: 1 Vatural 5 \square Pending Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral C Medical Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) and add 31. Date filed (Month Day, Year) 32. Registrar's Signature

State

Registrar

NOV 08

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		State Registrar					Cer	tificate	of E	Death			Reg. No	20	11	-38	181
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Examin	er				iber)					Location of D	Death			County of			
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na						•		and Number o						•	
and 2 Health				gh/Husband						t Maple							.55 ———
ge 1 and tof h	1		☐ Cremation	3 Removal from	State	20b. Plac cen	ce of Dispos netery, crem	sition (Nam	e of her plac	e) No	ov. Date	2,		ocation - C	-		
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		23a. Part	the disease, o	r complications that c	aused the	death.								LVEL	JPI.	Approximate	е
Physician/		Immediate Cause ((Final	only one cause on ea	ch line.	10	1 d =		~ ^·	- 0 1-						Interval Bet Onset and D	
Medical	9	disease or condition resulting in death)	on	a. Due to (or as a co	nsequer	nce of):		Os	3676					+		
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or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu	Certificate:	4 Homicide	detern	nined 28e. Place	of Injury - ng, etc. (S)		e, farm, stre	et, factory,	office			Location (S City or Town			or Rural	Route Numb	er,
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To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this ce completed filled in by the funeral director.	Medical	(Check 2	Medical	Examiner: On the bas g Nurse Practioner:	is of exami	ination a	nd/or invest	igation, in n	y opinio	on, death occur	rred at the t	ime, date ar	nd place	e, and due to	the ca	use(s) and ma	nner stated.
Vorthing Comp	2	29b. Signature and		-	4-				_	number	ia piace, an			te signed (/		-	
1		•	H	loh gr	yte	•		01	123	6189)	1110	120	110	
		30. Name and addr	ess of person	who completed caus	e of death	(Item 2	3a) (Type, P	rint)	- ,					- 11			
70		31. Date filed (Mont.	Day Veer	49 73		Her	1409	لايع	1110	ge P	IZE	aur	S	ulb	, VA	A 2019	25_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Shaw Clarence Lee T3. November 2011 6:15 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Hours (Month, Day, Year, 278-30-7829 Director 1 X M 2 | F 78 Oct. 24, 1933 Ohio Usual Residence of Deceden er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location the Maryland Director 1 Yes 2 XNo MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 2b901 USA 10117 Tenbrook Drive death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 X Yes 2 No If Yes, Give Korean Year or Dates Confl1 þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmait. life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence Shaw Garnet Yates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Grove/Daughter 14812 Peachwood Drive, Silver Spring, MD 20905 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State N2811 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD Parklawn Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retwo Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Non-Small Cell Lung Cancer 5 yrs disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to or as a conse uence of: Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year Month Pregnant at time of death ed by the a Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>수</u> Coronary Artery Disease Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital ည 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, lemo D35996 November 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda 2730 University Blvd. W., Silver Spring MD 20902 Burrell, MD

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

NOV 14 2011

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 8, Physician/ 7:09 Doris Anne Schachte 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg Montgomery 317 Midsummer Drive If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** July 24, 204-20-2576 83 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director MD Gaithersburg Montgomery 1 ☐ Yes 2 🛂 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20878 USA 317 Midsummer Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. Specify: White 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🖺 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) NASA Aerospace Contracting Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be 1. Department of Health and Mental Important; If item 27 is many injury or other. Lottie Bryan Gooch Thomas Joseph Magrann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 317 Midsummer Drive, Gaithersburg, MD 20878 Deborah Tolstoi/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 11, 1 🗆 Burial 🖄 Cremation 3 🗆 Removal from State Metropolitan Crematory 2011 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Ligen: le MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): D and Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2X No Month Year 5 Other (specify) 4 Pregnant g Unknown Pregnant at time of death sate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed?

1 Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) director, Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\frac{\text{\$X\$}}{\text{Residence}}\) 6 \(\sum \) Other (Specify) 2X No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? iniury 5 Pending 1 Natural within 24 hours after death. To the Funeral Director: A Investigation Accident filled in by the 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. соmpleted 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D37142 November 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Coleman, MD'

(Month, Day, Year) NOV 1 4 2011

2. Registrar's Signature

1355 Piccard Drive, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 MARY LOUISE SCROCCO NOVEMBER 7:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 224 MOUSLEY ROAD GRASONVILLE QUEEN ANNE'S Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Months Hours 08/12/193 80 PENNSYLVANIA Director 123-24-9876 Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director must be notified 28a-f MD 1 Yes 2 No QUEEN ANNE'S GRASONVILLE 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? Funeral 23a 224 MOUSLEY ROAD 21638 UNITED STATES ral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE If Yes, Give 3 X Widowed 4 □ Divorced Year or Dates if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ELECTRONICS BOOKKEEPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 PETER C. ROSSI BERNICE PETTENATI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANNE MARINIK / SISTER 224 MOUSLEY ROAD, GRASONVILLE, MD 21638 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery crematory or other place)
BONAVENTURE
CEMETERY 1 X Burial 2 Cremation 3 Removal from State ST. 4 ☐ Donation 5 ☐ Other (Specify) 11/14/2011 ALLEGANY, NY Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN
106 SHAMROCK ROAD, WALLESTER, 1 HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** countrally list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. CON (65) 10 and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) anding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) ed by the a detached f 1 Yes 2 9 I Inknown s been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) No 24a. Was an cate has t autopsy After this certificate Yes 2 K No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \nearrow Residence 6 \square Other (Specify, Hospital: 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accider 3 Suicide iniurv 5 Pending Investigation
6 Could not be Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

31. Date filed (Month, Day, Year) State NOV 1 0 2011 Registrar

(Check only one

> , M, D; H. WIKERON 204 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0027055

29d. Date signed (Month, Day, Year)

11/10/11

MEDICAL CENTER ROOM GRASONVILLE, MD 21638

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jack Anthony Santoriello November 2011 2:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis 1313 Harmony Lane 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex 1 **X** M 2 □ F **Funeral** Days 186-20-7290 82 Yrs Pennsylvania Director June Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Annapolis MD Anne Arundel 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21409 USA 1313 Harmony Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1946 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 1947 Specify. Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service Postmaster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marquerite Magnabosco Andrea Santoriello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1551 Shipsview Road Annapolis, MD 21401 Jackie Thorne / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Hillcrest Memorial 09 1X Burial 2 Cremation 3 Removal from State Nov. Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 Gardens 22 Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, Signature of Funeral Service Licensee Severna Park Funeral H Severna Park, MD 21146 P.A. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PAONOA Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death Unknown Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed eral Director: After this certificate filled in by the funeral director, page 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) __ Homicide determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b Signatu Name and address of person pleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

NOV 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 8:15 A NOVEMBER 2011 PALMER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK HOSPITAL FREDERICK FREDERICK MEMORIAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🗆 M 2 ី F Months Days Hours 89 Mary Land Director 217-24-9539 July Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a ·f show important: If item 27 is marked other than "natural", or items 23a or 28a ·f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State Funeral Director 1 ☐ Yes 2X No Middletown Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21769 8606 Myersville Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Remsburg Mary Malcolm Palmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8606 Myersville Road Middletown, Maryland Albert Lynn Shafer/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State Middletown, Maryland 11/15/2011 Zion Lutheran Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA Signature of Funeral Service 7606 Old National Pike Boonsboro, MD 21713 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Part 1 Enter the disease, or complication, or heart failure. List only one 23a. Part 1 DAYS Death Immediate Cause (Final Phy_i_ian/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last nding physician a use as the burial-Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 ours after death. eral Director: After this certificate if filled in by the funeral director, page 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: Medical Certificate: To 2 **X** No 1 💢 Inpatient 2 🗌 ER/Outpatient 3 🗎 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 8c. Injury at 1 X Natural injury work? 5 Pending .vatural
Accident
Suic 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only 29d. Date signed (Month, Day, Year) 29b. Signati 00062223 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 HOMAS TOMNION DUVE, PLEDELICE, MD 21702 BOLA LUM, TN-5 31. Date filed (Month, Day, 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Nevember Physician/ 958 PM 2011 Madaline Irene SPRINGER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Meritus Medical Center Hagerstown Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number (Month, Day, **Funeral** Days Months 1 □ M 2 😿 F 100 214-09-5072 1911 Director Jan. Maryland Usual Residence of Decedent 28a-f show 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland ms 23a or 28a-f shorms the special mast be notified at Director 1

Yes 2 □ No Maryland| Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number Funeral 1092 Virginia Avenue 21740 USA ural", or items? death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No ğ Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give "natural" 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Mfg. Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) alth and Mental H 27 is marked of traumatic even ပ Carrie M. Kennedy George William Socks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra Markle - Daughter 2138 Boteler Rd. Knoxville, Md. item 2 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State
 Donation 5 ☐ Other (Specific) Department of I Important: If its any injury or of once. Donation 5 Other (Specify) 11/16/2011 Hagerstown, Maryland Rose Hill Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home holes Of Rent 415 E. Wilson Blvd. Hagerstown, Md Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ DAY SER FORATE Medical resulting in death) Due to (or as a consequence of) **Examiner** FEW DAYS PROBABLY CASTRIC Se uentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 4 Pregnant
9 Unknown signed by the a 1 L Yes 2 L 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown VPPER KASTRO INTESTINAL BLECDING 24b. Were autopsy findings available prior to completion of cause of death? AVENIA PROSABLE OVARIAN 24a. Was an autopsy NESPLASM ARTERIOSCICROTIC CHROID VASCULAR performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 I ER/Outpatient 3 I DOA ျှ hin 24 hours after death.

the Funeral Director: After the mpleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death and on the cause(s) and manner as stated.

JW-6 State

within 2

Registrar DHMH 17 Rev 7/2009

Medical

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31. Date filed (Month, D

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DATTA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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rar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MILL IT MAGGESTOWN MOZITHO

D18019

29d. Date signed (Month, Day, Year)

NOV 13, 2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ach

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:0.5AM Glen Robert SMITH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Meritus Medical Center Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug. 8 , 1941 1 **X** M 2 □ F Days Hours 70 Maryland 218-38-1847 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Washington Fairplay 1 Yes 2 No 10e. Street and Number 17417 Lappans Road 10f. Zip Code 21733 10g. Citizen of What Country? U.S.A. ō the Medical Examiner must be Funeral 23a items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in LLS 14. Race - American Indian Black, White, etc. 0 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. þ 3 Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: 'natural", Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 land Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Heating and Air Cond. sheet metal mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Hazel Cline Ralph A. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Once. Maxine Smith - wife 17417 Lappans Road, Fairplay, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rest Haven Cemetery 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State November 2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pineral Service Licensee 22. Name and Address of Facility Minnich Funeral Home roberto 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval/Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or se-a Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown ☐ Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician; The law certificate has page 2 autopsy performed' death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after deau.

To the Funeral Director: After this committeed filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work Investigation 6 Could not be 1 🗌 Yes 2 🗀 No Accident 3 Suicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Ce fifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only Certifying Nurse Practioner: To the best of my knowledge, death of at the time, date and place, and due to the c 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) leted cause of death (Item 23a) (Type, Print) JW-5

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

		For State Registrar		ryland / D	epartment of F Certificate of D	lealth and M	lental Hygi			38192
Physicia Medic		1. Decedent's Name (First, Middle, Las Betty Poston Tu	•				2. Date of Death		2011	3. Time of Death 11:48 A M
Examin		4a. Facility Name (if not institution, give Anne Arundel Med	street and number)	r	4b. City, Town, or Annapo	Location of Death			County of Death nne Arundel	
Funeral Director		370 42 0037	m m - l	In yrs. last birtho 30 Y	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1930	g. Birthp Count Wash	olace (State or Foreign try) ington, DC
ıryland 1-f show ied at,	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar		10c. City, Town o	or Location SONVille		•		1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ral Dire	10e. Street and Number 820 St. George B			10f. Zip Code	 035	10	og. Citizen of USA	What Coun	
	To Be Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		13. Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)		ce - Americ ck, White, e	etc.
within 72 hour giene. er than "natur , the Medical I		15. Decedent's Ec (Specify only highest gra Elementary/Seconday (0-12) 12th	fucation		Decedent's Usual Occupa Give kind of work done of fe. DO NOT use retired) Civil Serva	during most of workir	^{rg} U	.S. De	partm	dustry lent
ld be filed Mental Hyy arked oth		17. Father's Name (First, Middle, Last) Sumpter Silcott	Poston			18. Mother's Name	e (First, Middle, Ma ell Thom		ne)	
nd 2 shou lealth and m 27 is m her traum		19a. Informant's Name/Relationship (Ty Susan Hamilton /			Mailing Address (Street a St. George					'
. Page 1 a tment of Η tant: If ite jury or otl		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery,	Disposition (Name of crematory or other place Crematory	11/10	0/2011	oc. Location Edgewa	ter,	MD
permit Depart Impor any in		21. Signature of Fureral Service Licens	ee		22. Name and Address 2973 Solom	ss of Facility Geo: ons Islan	rge P. K d Rd., E	alas F dgewat	unera er, M	1 Home ID 21037
Physician/ Medical		23a. Part 1 Enter the disease, or comp the ck, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	mphyse	ema	g, such as cardiac o	r respiratory arres	t,		Approximate Interval Between Onset and Death
Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c							
e be executed ysician and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c							
cate be e physiciar s the burit	edical	d								
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the beautied to the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal death	3 Ectopic pregnand 5 Other (specify)	у			ate of delive onth	ery Day Year
quires that ti en signed by uld be deta		Part II. Other significant conditions co	ontributing to death but	not resulting in	the underlying cause giv	ven in Part I.				ne cause of death?
The law rec ate has bee bage 2 sho	Completed by		-				24a. Was an autopsy perform	red?		osy findings available mpletion of cause of
cian: 'ertifica	Be (25. Was case referred to medical examiner?			26. Pl	ace of Death (Check	•	110		
Physic this or al dire	은	TLI fes 2 to No			oatient 3 DOA Othe	4 U Nursing Ho	me 5 🗌 Resider)
ttending F death. tor: After the funer	Certificate:	27. Manner of Death 1 Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be			work M 1 🗆	? Yes 2 \sum No	28d. Describe how			
pital or A		4 Homicide determined	building, etc. ((Specify)	n, street, factory, office		28f. Location (Stre City or Town,	State)		
the Hos ithin 24 hc the Fund impleted 1	Medical	(Check 2 ☐ Medical Exami only one) 3 ☐ Certifying Nurs	ner: On the basis of exa se Practioner: To the be	mination and/or est of my knowle	eath occured at the time investigation, in my opinio dge, death occurred at the 29c. License	on, death occurred at e time, date and place	the time, date and e, and due to the c	place, and du ause(s) and m	ue to the cau	use(s) and manner stated.
74." E≥E8		> Swee	Bech M		D	46052			5(11	Jay, rearj
40		30. Name and address of person who o			edial Pa	heway, a	mapol	is hy	0	
Stat		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	6-41					

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene _ State Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 7:20 P 2011 Ayline Tehansky November Μ. Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Frederick at Fredericktowne <u>Frederick</u> Tranquillity 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) (Month, Day, **Funeral** Year Country) PA Months 1 □ M 2 🕱 F Feb. 83 Director 125-22-7670 Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Frederick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 6441 Jefferson Pike 21703 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 HWidowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u>Homemaker</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blanch Upshaw ပ္ Stanley Smosna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard Tehansky/son 124 Westbury Park Way, Bluffion, SC 29910 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/09/2011 Frederick, MD Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death Other (specify) signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 Nursing Home_5 Residence 6 Cother (Specify, 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: iniurv 5 Pending Natural 2 🗌 No Investigation Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 0 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Muhammad

31. Date filed (Month, Day, Year)

NOV

Waseem.

0820

32. Registrar's Signature

1126 Opal Court.

Hagerstown, Maryland 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician/ 2011 5:25 P Taylor November Elizabeth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Williamsport Williamsport Nursing Home 8. Date of Birth (Month, Day, Year) Dec. 24 9. Birthplace (State or Foreign If Under 1 Year Social Security Number 7. Age (In vrs. last birthday) Funeral 1 M 2 X F Hours Months Days 79 **Director** Marvland 217-28-5189 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 No Williamsport Maryland Washington 10g. Citizen of What Country? 10f. Zip Code Funeral U.S.A 21795 <u>154 North Artizan</u> Street 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No 14. Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) al Hygiene. d other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Company Seams<u>tress</u> 12 Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other traumatic avores 17. Father's Name (First, Middle, Last) မ Pauline E. Smith Clarence W. Olden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland 21783 12938 Unger Road, Smithsburg, Connie J. Eichelberger/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/14/2011 Boonsboro, Maryland Boonsboro Cemetery Bast-Stauffer Funeral Home, P.A 22. Name and Address of Facility ognature of Funeral Service Licensee 7606 Old National Pike, Boonsboro, Maryland 21713 Approximate Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final TSPIRATION ANGUMBUTA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the attending physician and hed for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy
 Other (specify) _____ Live Birth 2 - Fetal death 3 Year Month Day in the past 12 months? Pregnant at time of death Yes 2 No detached 9 Unknown P.O. cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🗌 No 26. Place of Death (Check only one) **Division of Vital** funeral director, 25. Was case referred to medical Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပု this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 1105 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IED

DHMH 17 Rev 7/2009

State Registrar

ORIGINAL

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Rose WEINRIB 11:30 A M November 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Rockville Arbor Place Assisted Living 8. Date of Birth (Month, Day, Yo April 4, 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months 066-26-3899 1 🗆 M 2 🕇 F Poland 87 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 V No <u>Silver Spring</u> Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number United States 20901 10911 Oakwood Street 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂢 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Department Store 12 <u>Saleswoman</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leah 7usman Chaim Schwachsuff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10911 Oakwood St., Silver Spring, MD Lilly Schor, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Clifton, NJ 11/8/11 King Solomon Cemetery 4 ☐ Donation 5 ☐ Other (Specify)

Physician/ Medical **Examiner**

Physician/

Medical

Examiner

Funeral

Director

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Director

Funeral

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho amortant: If item 27 is marked other than "natural", or items 25a or 28a-f sho amortant in the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

and been signed by the attending physiciar should be detached for use as the buris within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	21. Signature of Liferal Service Lie	<u> </u>	Torionansky Hebrew 254 Carroll St., N	Funeral Home W, Washington	, DC 20012
	23a. Part Efter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not cause on each line. Alzheimer's Dem Due to (or as a consequence of):		c or respiratory arrest,	Approximate Interval Between Moreant Prain 5 Years
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
/Sicially integra	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	230	d. Date of delivery Month Day Year
ed by Fill	Part II. Other significant conditions con	tributing to death but not resulting in t	the underlying cause given in Part I.		contribute to the cause of death? No 3 Probably 4 Unknown
naidillo				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
ם	25. Was case referred to medical		26. Place of Death (Che	eck only one)	Assisted
0	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outp	patient 3 DOA Other:	Home 5 ☐ Residence 6 ☐	
care:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Tin inju	28d. Describe how injury or		
ll ceru	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	lumber or Rural Route Number,		
Medical Certificate: 10	(Chook 2 Medical Examine	On the basis of examination and/or i	eath occurred at the time, date and place investigation, in my opinion, death occurred edge, death occurred at the time, date and	d at the time, date and place, ar	nd due to the cause(s) and manner stated
_	29b. Signature and title of certifier		29c. License number	29d. Date s	signed (Month, Day, Year)

D 0035045

November 6, 2011

20832

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State

Registrar

31. Date filed (Month, Day, Year,

NOV 14 2011

Philip Henjum, M.D., 18109 Prince Philip Drive, #200, Olney, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 38196 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ November 4, 2019 a Edward J. Wisniewski 4:26 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 37275 Heath Court St. Mary's Mechanicsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 6 Sav 7. Age (In vrs. last birthday) **Funeral** Days New Jersey Hours 1 X XM 2 - F Director 127-10-2645 98 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2X XNo Maryland St. Mary's Mechanicsville ò 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 37275 20659 USA Heath Court items death v 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 ☐ No 1943— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates. 1945 1 ☐ Yes 2 ¥ No Specify. "natural", Specify: Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 years Cartographer Dept. of Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) c, Maryl.
permit. Page 1 and 2 should be.
Department of Health and Mental
Important: If item 27 is meany injury or other." and Mental I မ Wisniewski Zasadzinski Veronica 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37275 Heath Court Mechanicsville, MD Robert West 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date Resurrection Cem. 1 Burial 2 Cremation 3 Removal from State 11/11/2011 Clinton, Maryland 4 Donation 5 \(\infty\) Other (Specify) Entombment 21. Signat Funer Service License 22. Name and Address of FacilityGeorge P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ISCHEMIC CARDIOMYOPATHY quantelly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) -transit CORONARY ARTERY DISEASE Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be 2 📉 No Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D40203 November 8, 2011

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Battle MD 5530 Wisconsin Avenue

NOV 0 9 2011

trar's Signature

#700

Chevy Chase, Maryland

20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #17 WCHD State of Maryland / Department of Health and Mental Hygiene JW 11/18/2011 PerFor FH State
Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7:1 5P M Physician/ 1 197 1/11 Day Walter Edward Wright Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. Hours 231-66-7816 1XX 2 1 F Months 60 **Director** 12/2/1950 Virginia Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD Montgomery Rockville 1 Yes 2 X X 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 'natural", or items 23a o dical Examiner must be United States Funeral 20852 6060 California Cirde #209 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Black, White, etc. Armed Forces 1 X Yes 2 No If Yes, Give 1973-Year or Dates. 1995 þ 1 Never Married 2 Married 21215-0036 Specify: White 1 Yes 2XXNo Specify: Completed 3 Widowed 4 Divorced er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Government Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Energency Manager Be 18. Mother's Name (First, Middle, Maiden Surname) **Evelyn Pearl Andrevs** Maryland 17. Father's Name (First, Middle, Last) Grady Hartwell Wright 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6660 California Circle; Rockville, MD 20852 Department of Health ar Important: If item 27 is any injury or other trauonce. Lisa Wright/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/15/2011 1 Burial 2 Cremation 3 Removal from State Norman, OK 4 N Donation 5 ☐ Other (Specify) Cen Life Institute 21. Signature of Funeral Service Licensee

A. BlakkM016B 22. Name and Address of Facility 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St. Hagerstown, MD 21740 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Metastatic Pancretic Cancer 6 Months disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury -tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 as nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnan Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) 9 | Unknown P.O. ed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ischemic Bowel 1 Yes 2 No 3 Probably 4 Nown Records, Completed P 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No this certificate 1 ☐ Yes 2 😾 No Naite • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certifical eted filled in by the funeral director, I Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 Nnpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) of 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Division Investigation Accident Wright 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 3 [within 24 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059244 11-12-11 M.D GISELLE MERY, H. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20852 B10014302 Rockville, MD 25+1 30000 Kecutive 31. Date filed (Month, Day, Yea 32. Regist ar's Signature State Registrar

November

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 9 William Wells 2011 11:23 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 10130 Melody Lane Hagerstown Social Security Number Year If Under 24 Hrs 9. Birthplace (State or Foreign Sex 1 M 2 D F 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours April 8, 1932 Maryland 220-28-3717 79 **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10130 Melody Lane 21740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces?

1 Yes 2 XXNo Black, White, etc. 1 Never Married 2XXMarried þ Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan any injury or 1 ☐ Yes 2XXNo Yes Give Specify. 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 8 Education Principa. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harold Wells Katherine Ringer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina Wells - Wife 10130 Melody Lane Hagerstown, Maryland 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rose Hill Cemetery Nov.14,2011 Hagerstown, Maryland ign lare / Funeral / sborne AFilmerality Home, P.A. 425 S. Conococheague St.Williamsport,MD 21795 Enter the disease, or complications that caused the death. Do not enter the mode of dying, hock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending death. 1 🗌 Yes 2 🗌 No Accident
Suicide
Homicide Investigation within 24 hours ofter deal To the Funeral Director 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, ueatin occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce 30. Name and address of p ho completed cause of death (It

Registrar

State

DIDSON

31. Date filed (Mont)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2011 0740 A Irene Yost Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sunrise Assisted Living Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year_ If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Director 216-28-3225 84 1 🗆 M 2 🛡 Sept. 24, 1927 Bristol, England Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits at 10a. State 10c. City, Town or Location Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 990 Waterford Drive 21702 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 ♠ No If Yes, Give Year or Dates. within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify Specify. "natural" Completed 3 Widowed 4 Divorced White al Hygiene. I other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ Frank Yost Louise Broomsgrove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health Robert A. Yost 24300 Kakae Drive, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory of other place, Lakeview Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov.19,2011 Sykesville, Maryland 22 Name and Address of Facility Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Efter the disease, or complications the shock, or heart failure. List only one cause on or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final neumonia Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has perform 1 ☐ Yes 2 ☐ No Yes 2 X No Division of Vital funeral director, 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) Assisted UVIAS examiner? Hospital 2 X No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After X Natural 5 Pending work Accident М 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 7/2011 5 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre Cak 7900 State Registrar

11-08319 Sophie Zarkowski

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # State of Mary and / Department of Health and Mental Hygiene

2011 38200

		1- For State Registrar	rtificate of	Death		Reg. No.		
Physicia edical Examir	ın/	Decedent's Name (First, Middle,Last)	-		Date of D Month	Day Year	3. Time of Death 0831 hrs	
euicai Examiii		Sophie Zarkowski 4a. Facility Name (if not institution, give street and number)		b. City, Town, or Location		per 6, 2011 4c. County of Deal		
, F		7600 Laurel Bowie Road		Bowie		Prince George's		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I	ast birthday) Yrs.	Months Days Hou	re Min	8 irth (MM/DD/YYYY) 9. 8i 7,1914 C	rthplace (State or gn gn puntry) Pa.	
í a		Usual Residence of Decedent 10a. State 10b. County 10c. City,	, Town or Location	on	 		10d. Inside City Limits	
		Maryland Prince George's Bow	ie				1XXXes 2 No	
Maryland 28a-f show d at once.	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	untry?	
with the Maryland ns 23a or 28a-f sho be notified at once.		7600 Laurel Bowie Road		20715		USA		
death r iter	Funeral	11. Marital Status 1 Never Married 2 Married 3 Never Married 4 Divorced If Yes, Give Yeer	If Ye	s Decedent of Hispanic Or es, specify Cuban, Mexica	n, Puerto Rican, etc.)	White, etc.	rican Indian, 8lack,	
irs afte	<u>۾</u>	3 Widowed 4 Divorced If Yes, Give Yeer or Dates: 15. Decedent's Education (Specify only highest grade completed)		Yes 2 X No specify		Specify: 16b. Kind of 8usiness	White /Industry	
215-0036 be filed within 72 hours after ntal Hygiene. rked other than "natural", e ent, the Medical Examiner:	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Agricult Own Home					
5-0 lied wi Hygie I other		17. Father's Name (First, Middle, Last)			er's Name (First, Middle			
	B	Jacob Borkowski 19a. Informant's Name/Relationship (Type, Print)	19h Mailine		ctoria Warq	Jacki lumber, City or Town, Stat	o Zin Codo)	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatit en	٩	Cecilia Germaine/ daughter		Wakefield La		_	e, zip Gode)	
G, P. 1 and 1 Health		20a. Method of Disposition 20b.		ition (Name of cemetery,	Date	20c. Location - City o	r Town, State	
Baltimore, permit. Pages 1 ar Department of Hes Important: Tites injury or other tr		4 Donation 5 Other Specific	ıntt Cre	ematory	11/9/11	Waldorf, M	d.	
Salti emit. epartir ijury c	ı	21. Signature of Funeral Service Licensee PET	DVR 22. N	ame and Address of Facil	iv Robert I	E.Evans Fune	ral Home	
	-	William Allen Smith M00544 23a. Part I. Enter the disease, or complications that caused the death				owie, Md. 20	/ I 5 Approximate Interval	
Physician Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence or condition)	lerotic Cardi				Between Onset and Death	
		Sequentially list conditions, b	•,-					
	Ē	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause	if).					
ted nsit	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of the	र्ग):					
'60, sate be executed chysician and ne burial - transit	Medical	d. UNPENDED AMENDED		· · · · · · · · · · · · · · · · · · ·			<u> </u>	
		IF FEMALE: 23c. If yes, outcome of preg	nancy			23d. Date of delive	у	
Box 687 death certific the attending ped for use as th	Physician/	23b. Was decedent pregnant in the past 12 months?		tal death 3 Ector ner (Specify)	oic pregnancy	Month	Day Year	
Box death	ysic	1 Yes 2 No 9 Unknown 9 Unknown	3 Ott	ner (Specify)				
P.O. Bc	<u>S</u>	Part II. Other significant conditions contributing to death but not r	esulting in the u	nderlying cause given in F		d tobacco use contribute to Yes 2 No 3 Pro		
on of Vital Records, P.O. rading Physician: The law requires that the thin. The After this cert ficate has been signed by the funeral director, page 2 shruld be detach.	Completed				pe	topsy prior to rform <u>ed</u> ? death?	utopsy findings available completion of cause of	
Rec n: The lificate		25. Was case referred to medical		26 Place of Deatl	1 Ye	s 2 No 1 V	es 2 No	
Vital hysician: this certifical director,	To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient	Other 5		Residence 6 🗸 Othe	er: Scene	
	tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury FOUND: Day, Year) Nov 6, 2011	28b. Time of Ir FOUND: 0820 hrs	njury 28c. Injury at Wo	 Subject fe 	e how injury occurred		
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined (Specify) Nursing He	ome, farm, stree	et, factory, office building,	or Town	n (Street and Number or R n, State) I Bowie Road, Bowie, I		
o the Hos vithin 24 ho o the Fun	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.						
F 2 F 3	ž	29b. Signature and title of certifier		29c. License numbe	r	29d. Date signed (Me		
N/A		シー・ソー・		O.C.M.E.		November 7, 20	717	
26		Name and address of person who completed cause of death (Item Donna M. Vincenti, MD Assistant Medical Exar	miner 900	W. Baltimore Stree	t, Baltimore, MD 2	21223		
St	ate	31. Date filed (Month, Day, Year) 2011 32. Redistrar's Signati	ure A	estal			•	

38201 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER Physician/ 0613 2011 Phyllis Bernadette Anderson Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SINAI HOSPITAL OF BALTIMORE N/A BAUTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 214-50-1082 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours **Director** 1 M 2 F 65 11/07/1946 Maryland or 28a-f show notified at show 10d. Inside City Limits 10c. City, Town or Location 10a. State death with the Maryland Director 1 XYes 2 No Baltimore N/A MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 9 ritems 23a or ner must be r Funeral U.S.A. 2121 Windsor Garden Ln. AptA103 ANDERSON Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. the Medical Examiner Armed Forces Black, White, etc. ö by 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12)
12th Grade College (1-4 or 5+) Homemaker N/A t. Page 1 and 2 should be filed wit rtment of Health and Mental Hygie rtant: If item 27 is marked other ' jury or other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ည Dubois Churchhill Doris Paraway 19a. Informant's Name/Relationship (Type, Print) 195 Mailing Address (Street and Number or Bural Route Number City of Turn, Alaro 3 Code)
2121 Windsor Garden Lane Apt Apt Maro 3 Code)
Baltimore, MD 21207 Shayla Walker(daughter Department of Health Important: If item 27 any injury or other the once. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 11/29 Baltimore, MD Joseph Adress Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line INTRACRANIAL HYPERTENSION Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** HEAMORRHAGE SUBDURAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): CHATTER TON APPROVED BY Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsv performed 1 Yes 2 No Yes 2. No To the Hospital or Attending Physician; The certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 💋 No nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: BEALER E 1 Natural 2 Accident 5 Pending UNWITHESSED SEIZURE, FALL 11/21/2011 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined BALTIMORE, MARYLAND 21207 HOME, 2121 WINDSOR GARDEN IN within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Name Fractitioner: The basis of the cause is and manner as stated. 3 29b. Signature and title of cept 29d. Date signed (Month, Day, Year) 29c. License number 11/25/2011 1518273986 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REYAD, MO BALTIMORE SINAL HOSPITAL OF ASHRAF 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Known

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38202 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 28, 2011 Janis Berzins, 9:01P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 219-26-9847 **Director** 1 🕅 M 2 🗆 F 71 February 12,1940 Latvia ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Maryland Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 14220 Manor Road 21131 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: It Yes, Give Year or Dates 1963-1965 Specify: White "natural", 3 Widowed 4 Divorced injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Janis Berzins, Sr. Anna Zalite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is
any injury or other trau Sharon Berzins/ wife 14220 Manor Road, Phoenix, MD 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 11/30/2011 Towson, Maryland 22. Name and Address of Facility Towson, MD 21204 21. Signature of Funeral Service Ruck Towson Funeral Home, Inc. 1050 York Road Tax ctaga 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one lause on each line. Approximate
Interval Between
Onset and Death
HOURS Immediate Cause (Final Physician/ ACUTE AORTIC DISSECTION disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the bunal-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autopsy performed? Yes 2 No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: ပ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one 29b. Signature 2 29d. Date signed (Month, Day, Year) 11/29/11

Registrar DHMH 17 Rev 06-2011

State

30V

JEFFREY SELL

31. Date filed (Month, Day, Year)

s of person who completed cause of death (Item 23a) (Type, Print) Y SELL 7501 OSLER DRIVE TOWSON, MD 21204

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38203 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov. 30, Physician/ 2011 12:45 A M Richard C. Benton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 15009 Lavale Monkton Road Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours 212-36-7071 Director 1 X M 2 🗆 F 71 Mar. 19, 1940 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Baltimore Monkton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 15009 Lavale Road 21111 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black White, etc. ģ 1 Never Married 2 XXMarried 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry oe filed with. Hal Hygiene. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Corvette Restorer Restoration marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental Fis marked o of Health and Ments fitem 27 is marked rother traumatic e Elizabeth Corbin Edgar Τ. Benton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print, 15009 Lavale Road Monkton, Maryland 21111 Donna C. Benton/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 12/6/11 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or condications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ BLADDER CANCER Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) burial-t attending physician Physician/Medical certificate be 68760 the 38 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Day 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> DICETTSEI ARTENIA Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? DISEASE • Hospital or Attending Physician: The 24 hours after death. • Funeral Director: After this certificate b MENAL 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier Dural TWA D21394 11/30/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DINALD T. WEGVELN 6535 N, CHARLE ST TUWSOW, M. ? 12V

Registrar

DEC 0 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 04:56 AM Michael Anthony Battle Sr. Vovember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 217-69-2613 **Director** 1 XM 2 🗆 F 10/18/1959 N.Carolina 52 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at Director Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21230 630 Scott St. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. er than "natural", or ite the Medical Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No þ Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Construction Co. Laborer 12th Grade other of Health and Mental Hyg item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bloss Battle Jr. Dorothy L. Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 630 Scott St., Baltimore, MD 21230 Rita Battle(sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 2/07/11 Baltimore, MD Joseph H: of Brown Jr. Funeral Home PA Signature 2140 N. FUlton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Pneumonia week disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Carcinoma of the tongue Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events >1 year HIV/AIDS as the burial-tran Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical death certificate be Box 68760 IE FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Number Fractitioner: In the best of my knowledge, death occurred at the time, date and place, and die to the cause(s) and manner stated (Check 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 201 E. University Parkway, Baltimore, MD 21218 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	ror	State of Maryland /				/lental Hyg	jiene		
		_1	State Registrar		Cen	tificate of D	eath	Reg. No. 2 38 245			
	Physicia		1. Decedent's Name (First, Middle, Last)	Bickel				Month Novem	Day	ear 20 11	
	Medic	al -	Lieselotte Ha. Facility Name (if not institution, give str	30.1	- 1	4b. City, Town, or	Location of Death	1 TOVERNE	4c. County of		011302
	Examin	er i		Drive		Gilen (Anne	An	indel co.
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthp	place (State or Foreign try)
	Director	_ h	162,20,01	M 2 LOVE 89	Yrs.	World S Dayo	Tiodio timin	ouly 10;	1922		many
-	nd at	. h	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Loc	ation				1	0d. Inside City Limits
	arylar a-f sl ified	ect	MS Ame Any	del co. Gre	·~ (Burnie					1 ☐ Yes 2 🗷 No
	or 28	흐	10e. Street and Number	inch co OIL	4.	10f. Zip Code			10g. Citizen of Wh		itry?
	s 23a ust b	Funeral Director	516 Arbor	Drive		210			United	5	states
	death item		II. Walital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. V	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	Americ White,	
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	☐ Yes 2 No	Specify:		Specify:	wh	ite.
0	hours natura ical E	lete	15. Decedent's Edu	cation 16	a. Deced	ent's Usual Occupa	ation	ina	16b. Kind of Bus	iness Inc	dustry
215	in 72 e. han "r Med	ᇍ	(Specify only highest grade Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	ind of work done a NOT use retired)		uiig	0	1.3	lome
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and B	ild be filed v Mental Hyg narked oth natic event,	To B	17. Father's Name (First, Middle, Last)					nown	vialderi Surriame)		
Š	should be filed wit n and Mental Hygie is marked other raumatic event, th		Un Known 19a. Informant's Name/Relationship (Type	Print)	Ph Mailin	g Address (Street a			: City or Town, Sta	te, Zip (Code)
<u>B</u>	1 and 2 should be filed within 72 hours after death with the Maryland if heath and Mental Hygiene. If heath and Mental Hygiene. Other T is marked other than "natural", or items 23a or 28a-f show either traumatic event, the Medical Examiner must be notified at		Mrs. Sebrina L	. 1 1		8 Arbon					
re,	1 and of Hez item		20a. Method of Disposition	20b. Place	tery cren	sition (Name of natory or other place	e)	Date	20c. Location - 0	-	
<u>n</u>	Page nent c ant: If ury or		1 ☐ Burial 2 🖾 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	intic	. Grema	ton 12/c	4/2011	Glen P	NIV M	e mo
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once.		21. Signature of Funeral Service Lio		22	. Name and Addres	ss of Facility Si	ngleton	Funeral	& C1	remation
	TU = 40	Н	23a. Part 1. Enter the disease, or compli	7 /						TILLE	Approximate
			shock, or heart failure. List only one	cause on each line.	- 0	Dm-	Ford	lik?			Interval Between Onset and Death
	ਅਤਾਂciaਜ Medical		disease or condition resulting in death)	Due to (or as a consequenc	e of):	Spazin					
Examiner Ceronary along Os									000	_	
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8	ate be executed physician and the burial-transit	xan	Cause (Disease or iinjury that initiated events resulting in death) Last	. Due to (or as a consequenc	e of):					\dashv	
) '	be exe	dical E	resulting in additing East	,							
760	icate g phys is the	ledi									
89	certif ending use a	an/N	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de	ath 3	Ectopic pregnanc	cy			of delivery th Day Year	
Bo	ss that the death certifica igned by the attending p be detached for use as t	Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of deat 9 ☐ Unknown		Other (specify) _			Mor	tn	Day fear
Division of Vital Records, P.O. Box 687	at the d by th etach	P.	9 ☐ Unknown Part II. Other significant conditions cor	tributing to death but not resulting	ıg in the ι	ınderlying cause gi	ven in Part I.	23e, Did t	tobacco use contribute to the cause of death?		
ď.	res tha signer	d by		Ω				1 🗆	Yes 2 No	3 🗌 Pro	obably 4 🗆 Unknown
ord	v requires s been siç should b	ete		Kne	uor	nia		24a. Was		ere auto	opsy findings available
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al H	an: The tificat tor, pa	Be C	25. Was case referred to medical			26. P	lace of Death (Che				trien.d3
Ζţ	hysici nis cer i direc	P	1 L Yes 2 No	ospital: 1 Inpatient 2 ER							y) Residence
o of	ing Pl	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	o. Time o injury	worl		28d. Describe	now injury occurre	d	
sior	ttend death stor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	, farm, str		res 2 LINO	28f. Location (Street and Numbe	r or Rura	al Route Number,
) Xi	after after Direct d in by		4 Homicide determined	building, etc. (Specify)				City or To	vn, State)		
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	Chaok 2 Medical Evamin	cian: To the best of my knowledger: On the basis of examination an	d/or inves	stigation, in my opini	ion, death occurred	at the time, date	and place, and due	to the c	ause(s) and manner stated.
	the H hin 24 the F mplete	Me	only one) 3 Certifying Nurse	Practioner: To the best of my kn	owledge,	death occurred at the	ne time, date and p	ace, and due to the	ne cause(s) and ma	nner as s	stated.
	5 × × × × 5 × × × × × × × × × × × × × ×		29b. Signature and title of certifier	our	2_e		4 68 1 Ce		11 /	28	2011
	8		30. Name and address of person who co	empleted cause of death (Item 23	a) (Type.		70010		. /		
				^ \	19	7575 Ri	tchie Hig	ghway, G	len Burn	ie,	MD 21061
	Sta Registi		31. Date filed (Month, Day, Year) DEC 0 1 2011	32. Registrar's Signature	arks	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar North charles Street

3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5901

32. Registrar's Signature

2011

Baltimore marylans

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38207 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26, 2011 November 3:00 PM Adam Denmead Cockey, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Parkville Oak Crest Care Center Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 X M 2 D F 213-14-9103 11/30/1921 Maryland 89 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marked once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Parkville 1 🗌 Yes 2 💆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd # 108 21234 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Contracter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Fitzhuah Lee Cockey Margurite Colgate Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $21030\,$ 10531 Willow Vista Way Cockeysville, Maryland Adam D. Cockey, Jr. / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Dulaney Valley Mem. 1 X Burial 2 Cremation 3 Removal from State 11/30/2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility_Ruck Towson_Funeral_Home, Inc. Signature of Funeral Service 1050 York Road Towson, Maryland 21204 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injurthat initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician Physician/Medical Hospital o Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1 Yes Yes 25. Was case referred to medical fureral director, 26. Place of Death (Check only one) Be Other: ၉ 1 Yes 2 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Di ector: After this Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Within 2 To the F the only one) 29b. Signature and Ittle of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3+1V WALThe DEC 0 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wilfred Couturier 2011 11:15 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Westminster 706 Wildlife Court Carroll County 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Pay, Year) Apr 15, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 🗙 M 2 🗆 F 88 1923 Massachussetts **Director** 018-14-6416 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Carroll County Westminster 10e, Street and Number 10a. Citizen of What Country? Funeral 706 Wildlife Court 21157 China 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 9 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Fire Arms Elementary/Seconday (0-12) College (1-4 or 5+) Tool + Die Maker Production Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ဂ္ Wilfred Couturier Rosanna (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Jeanne C. Keruly (Daughter) 201 Taplow Road, Baltimore, Maryland 21212 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of h Important: If ite any injury or ot 20c. Location - City or Town, State 1 🔲 Burial 2 🗶 Cremation 3 🗆 Removal from State Green Mount Crematory 12/1/2011 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of unerationvice a leaves of Martin D. Lawson MINCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any leading to immediate Due to for as a consequence of if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events death certificate be executed Due to (or as a consequence of): resulting in death) Last physiclan a s the burial-Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Year 1 L Yes 2 L 9 D Unknown q 🗌 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed' Hospital or Attending Physician: The 2 3 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗗 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA After the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

e Funeral Director After a Funeral Director After a Funeral Director After a Funeral British and a Funeral British Br work 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and one to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 52435 3 2 20/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, Maryland 21157 Binu Chacko, MD, Stoner Avenue,

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)
DEC 0 1 2011

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney 38209 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 27, **Physician** 2011 2:15 A M SHEN HUA CHEN November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/AFUTURE CARE AT NORTH CHARLES Baltimore 8. Date of Birth (Month, Day, Year) Sept 24, 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
China 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1**∑**M 2□F 48 Yrs 1963 214-73-0824 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10b. County 7 is marked other than "natural", or iteme 23a or 28a-f shov traumatic event, the Madical Examination as the notified at 1 ☐ Yes 2X No Director Towson Maryland Baltimore County 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1679 Thetford Road 21286 China death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. s filed within 72 hours after d I Hygiene. other than "natural", or Iten 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Chinese 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Retail Food Services Elementary/Secondary (0-12) College (1-4or 5+) Bus Boy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill iment of Health and Mental H tant: If Item 27 is marked ott Be Sheng Pei Chen Xiu J. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1679 Thetford Road, Baltimore, Maryland 21286 Yan Chang Cao (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If ite
any injury or of 1 XBurial 2 Cremation 3 Removal from State Lorraine Park Cemetery 12/1/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur/ Finera Servic Long Wascon

Martin D. Lawson 2 Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Nasophanuea cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for usa as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical usa as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan has autopsy certificate 1 Yes 2 No the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: Wursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 ☐ Mo this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 1 Natural 5 Pending death. 1 Tes 2 No investigation 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 201 D70785 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dimitra Mitsuni, M.D., 821 N. Eutaw Street, #308, Baltimore, MD 21201 31. Date filed (Month, Day, Year)
DEC 0 1 2011 32. Registrar's Signature State Registrar

X

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar 29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ord Casellaria confront MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

GUILLERMO JOSÉ GIANGRECO BOI HOSPITAL DRIVE, GLEN BURNIE, MD 20161

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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HOUEHBERZGIZOII

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | | 3821 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 28^{ay} Month Nov. 2011 Physician/ 2:02 a M Jack Calhoun Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 4418 Wine Rd. Westminster If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Tenn. 8. Date of Birth June 14,1923 Social Security Number 7. Age (In vrs. last birthday Funeral Months Hours 1 🔀 M 2 🗆 F 410-30-8973 88 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 💢 No Westminster Carroll Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 U.S.A. 4418 Wine Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married Yes 2 XNo þ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Timber Logger 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Heaton David Scott Calhoun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4418 Wine Rd. Westminster, MD. Charlotte Calhoun - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 20c. Location - City or Town, State 3^{Dat}2011 1 Burial 2 Cremation 3 Removal from State MD. John Luther Miller Cem. Westminster, 4 Donation 5 Other (Specify) 21. Signature of June al Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A 21102 3296 Charmil Dr. Manchester, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause operach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No 2 - No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 1 Natural 5 Pending 2 \square No Investigation Accident the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co Center St. Wistminster, MD 01157

Registrar

State

Date filed (Month, Day, Year)

DEC 0 1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10419 Cox 2011 Nov . Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (if not institution, give street and number) Examiner Baltimore Medica Center Baltimore, 8. Date of Birth
(Month, Day, Year) g, Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours 1 M 2 F Maryland 213-12-689 90 Director Usual Residence of Decedent 10d. Inside City Limits items 23a or 28a-f shov ier must be notified at 10c. City, Town or Location 10a State should be filed within 72 hours after death with the Maryland Director 1

Yes 2 □ No Baltimore MD N/A 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21217 301 McMechen St. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status "natural", or iter Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Government Administrative Clerk 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beulah McClaine Harry Noisette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10457 Ridgewater Ln., San Diego, CA 92131 Darlene McKinnon(niece) 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Balto. Nat'L Cem 12/02/11 Baltimore, MD Josephoder of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ardiopulm ₽nysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) signed by the sid be detached f g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy performe within 24 hours after death.

To the Funeral Director. After this certificate be completed filled in by the funeral director, page 1 Yes 2 No 1 Yes 2 1 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 **V** No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifie Edmund Hong 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Baltimore MD 21201 Saint Medica Mercy

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Pay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38213 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FRANCIS NOVEMBER 29 2011 DAVIDSON 12:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GENESIS ELDERCARE BALTIMORE TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 DM 2 DT Months Days Hours 03/26/ 75 219 32 3573 Director MARYLAND 1936 Usual Residence of Decedent 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE PARKVILLE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9202 AVONDALE ROAD 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE If Yes, Give KOREA Year or Dates. 1 Tes 2 No Specify. 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) unk College_(1-4 or 5+) ASBESTOS WORKER **ASBESTOS** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည WILLIAM DAVIDSON SR. BEATRICE HARDESTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NICOLE WEIGMAN/ATTORNEY 10 NORTH CALVERT ST. BALTIMORE, MD 21202 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State OAKLAWN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 12/02/11 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a contaction of that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day 1 Yes 2 L 9 Unknown P.O. ed by t signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law has page performed? Yes 2 Z No 1 ☐ Yes 2 🖾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nersing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pendina after death. 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29/4 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SADIA YURA RUAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#196.perFH, G922, 1275/2011 WS
State of Maryland / Department of Health and Mental Hygiene 2 1 38214 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 28, 2014 Physician/ Charles Dove Webster 1:30 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Edenwald If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** ^{Year)} 19<u>22</u> Days Hours Min May 24 Mary land 1 ₩ 2 □ F 89 Director 218-18-0772 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d Inside City Limits ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🂢 No Maryland Towson Baltimore 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21204 U.S.A. 1100 West Joppa Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Completed by 1 TZ Yes 2 No If Yes, Give T.T. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Specify: Year or Dates. WW II "natural", 3 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Law Attornev Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mamie S. Morwitz Charles Webster Dove 19a. Informant's Name/Relationship (Type, Print) Patricia Cavanaugh Dove / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 12/5/2011 Towson, Maryland 4 Donation 5 Other (Specify) 1050 York Road Inc. Towson, Md. 21204 21. Signatur of Fu al Service Linesee 22. Name and Address of Facility Ruck Towson Funeral Home Approximate Interval Between 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only of ns that caused the death. Do not enter the mode of dying, such use on each line Ons and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequency of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a conseque Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Other (specify) Pregnant at time of death filled in by the funeral director, page 2 should be detached Unknown been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ĝ 1 Tyes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manual of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred Natural 5 Pending iniury 2 🗆 No Investigation Accident Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Checl 3 29b. Signature and title of cer 29c. License number 29d. Date signed Name and address ause of deat State Registrar DHMH 17 Rev 7/2009

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2011 38215 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

_		1- For State Registrar	C	ertificate of			_	g. No.		
Physic		Decedent's Name (First, Middle,Last)				***	2. Date of Death		3. Time of Death	
াcal Exan	ninei	_ OOMCG D. Dat					November		2325 hrs	
		4a. Facility Name (if not institution, give s Johns Hopkins Hospital	treet and number)	['	Baltimore	or Location of Death	1	4c. County of Death		
Funera		Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Ye	ear If Under 24Hrs	s, 8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or	
Directo		220-82-5833 1XN	1 2□F 36	Yrs	Months Da			Foreign	n Intry) MD	
any		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Locati	on			· 1	10d. Inside City Limits	
E .		MD	В	altimor	e				1 Yes 2 No	
Maryland 28a-f show	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Coun	try?	
eath with the Maryland items 23s or 28s-f sho ust be notified at once.	Dir	1238 E.Coldspri				239		USA		
death wi	Funeral	1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces?1 Yes 2 No.	If Y		lispanic Origin? (S an, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,	
after	J. P.	3 Widowed 4 Divorced If	Yes, Give Year r Dates:	1	Yes 2 X N	-		Specify: Bla		
hours fratur Exam	bed	15. Decedent's Education (Specify only Elementary/Secondary (0-12)) 16a. Deceden during me		ation (Give kind of e. DO NOT use ret		16b. Kind of Business/Ir	ndustry	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Memal Hygiene. Instit 1 fitten 27 is marked other than "matural", or items 23a or 23a-f ahe or other trannarie event, the Medical Examiner must be notified at once	Completed	12th	College (1-4 or 5+)	Main	tenanc	e		Shopping	Center	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If iten 27 is marked other than injury or other transmic event, the Medica.	Be Co	17. Father's Name (First, Middle, Last) John Daughtry					e (First, Middle, M: ll Cart			
21; ould b d Men is mar	먇	19a. Informant's Name/Relationship (Typ						per, City or Town, State,		
MD 2 sho alth and m 27 is		Sherrell Daught					-			
of Her tr		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	b. Place of Disposi crematory or oth	er place)			20c. Location - City or 1	, -	
Baltimore, permit. Pages I an Department of Hee Important: If ite	П	4 Donation 5 Other Specify.						Balto,		
Ball permit Depar Impor	1	21. Si ce License		40 1	4 L Z L L .	Presto	n St. B	eral Home	21213	
Physician	failure. List only one cause on each line. Respiratory arrest with Hypoxia complicating								Approximate Interval Between Onset and	
/Medica Examine		Immediate Cause (Final disease a. agitated behavior, biventricular cardiac								
	or condition resulting in death) Due to (or as a consequence of): hypertrophy, myocardial fibrosis and dysplastic b. Due to (or as a consequence of): hypertrophy, myocardial fibrosis and dysplastic									
	Examiner	cause. Enter Underlying Cause		c nodal	arteries	s associa	ted with	physical		
ecuted and transit		(Disease or injury that initiated events resulting in death) Last d.								
'60, sate be executed physician and he burial - transif	g	UNPENDED #23a,27,28a-f per me,g925,03/27/2012dhb IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver								
3760, ficate be g physicals the burnies		IF FEMALE: 23b. Was decedent pregnant in the	23c, If yes, outcome of pr		al doath 3	Ectopic pregna	incv	23d. Date of delivery Month D	ay Year	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/	past 12 months?	4 Pregnant at time of	do ath	al death 3 ner (Specify)	Ectopic pregna		I WOTH D	ay real	
. BO) he deatl y the att	چّ		9 Unknown ontributing to death but no	at socialting in the co	adoubline on to	aiven in Best I	230 Did tob	acco use contribute to ti	no cause of death?	
i, P.O. ires that th signed by	Š	Tart is Other significant conditions	muniputing to death but no	rresulting in the d	ilderlyllig cause	given in Fait i.		2 ✓ No 3 Proba		
Records, The law require ficate has been si page 2 should b	Completed						24a. Was ar		opsy findings available	
e law te has ge 2 sl	틸	-					autopsy perform 1 ✓ Yes 2	ned? death?	ompletion of cause of	
tal Rection: The Coertificate		25. Was case referred to medical			26.Plac	e of Death (Check		No 1 ✓ Yes	3 2 No	
Vita ysicia this ce	To Be	examiner? 1 ✓ Yes 2 No	pital: 1 ✔ Inpatient 2	ER/Outpatient	3 DOA	Other Nursin	ng Home 5 R	esidence 6 Other:		
ing Pl	<u> </u>	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Ir	` _	ury at Work?		w injury occurred		
Sion ttend death. ctor:	ją;	1 Natural 5 Pending 2 Accident Investigation	10/29/2011		4.	Yes 2 X No	Unknow			
Division of Vital tal or Attending Physician: is after death. In Director: After this certicled in by the funeral director	Certification:	3 Suicide 6 X Could not be determined	28e. Place of Injury - At (Specify) Hosp		t, factory, office	building, etc.	or Town, Sta	reet and Number or Run ate) 600 N. Wo	olfe Street	
Lospit: 4 hour 7 uners		4 Homicide	To the best of my knowle		ed at the time of	late and place, and	Baltimor	HOST	s Hopkins pital)	
Division To the Hospital or Attendenthin 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: O	n the basis of examination and manner stated.	n and/or investigati	on, in my opinio	n, death occurred a	at the time, date ar	nd place, and due to the	cause(s)	
8 4 8 4	≌	29b. Signature and title of certifier	Marinor stated.		29c. Licen	se number		29d. Date signed (Mon	th, Day, Year)	
		- m	1.11	/	O.C.	.M.E.		November 26, 20	11	
-		30. Name and address of pers who con	. ,	,			NAD 242			
			ief Medical Examin		altimore Str	eet, Baltimore	, MD 21223 			
S Regis	tate strar	31. Date filed (Month, Day Xeer)	32. Registrar's San	arul arks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38216 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Katherine S. Elliott 10:00 P M 2011 Medical November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Nun 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** If Under 1 Year Days Min (Month, Day, Year) 392-18-0369 **Director** 1 M 2 X F 89 June 20,1922 Usual Residence of Decedent Wisconsin 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Road 21093 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 ¥ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Dietician Health permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, is Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Jacob Seubert Kathryn Sophia Kauffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Gill/Daughter 1220 Bank Street Unit 501, Baltimore MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Hillton Service Corp. 4 Donation 5 Other (Specify) 12/01/2011 Towson, Maryland 21. Signatur ¶ Funeral Servic

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€ 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on bach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate oduce. Etter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 X No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MS0711158 12V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

DHMH 17 Rev 06-2011

10:00 р.ш.

NOVEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 38217 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month 4:12 P Donita Forehand November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Seasons Hospice Baltimore Randallstown Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 06-24-60 Min. 51 214-64-5980 Director MD 1 🗆 M 2 🔀 F Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD ND 1 X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2103 Windsor Avenue 21215 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian.
Black, White, etc. African "natural", or ite Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: Specify: American 3 ☐ Widowed 4 ☐ Divorced Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) other traumatic event, the 10th Grade U.M.B.C. Dietary Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Henry Forehand Susie Shaw Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dinita Forehand-Sister 2103 Windsor Avenue Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of Mt. Zion Cem. Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12-08-11 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Nasopharyngeal disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Phystcian: The law requires that the death certificate be executed hin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Yother} \) (Specify) has pice 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 👱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MS RajapuneM.D D0057465 11/25/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore MD 21209. 2835 SMITH N 5203 N-5 Rajapa KSC/M.D 32. Regis ar's Signature

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 17:56 PM Lorraine Feher 28 2011 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel Co. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** (Month, Day, 1 □ M 2 😾 F Months Days Hours **Director** 047-50-5900 Feb. Connecticut Usual Residence of Decedent 28a-f show 10a, State 10b. County with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Co. Glen Burnie 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6370 Centennial Circle 21061 United States death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , 0 1 Never Married 2 Married δ Yes 2 X No 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 'natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker yr. and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Russell Reinwald McClellan Jessie traumatic Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 Department of Health a Important: If item 27 is any injury or other trains Mr. Gabor Feher / Husband 6370 Centennial Circle Apt C, Glen Burnie,MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 12/7/2011 Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Se 22. Name and Address of Facility Singleton Funeral & Cremation 110 M01121 1 2nd Ave SW; Glen Burnie, MD 21061 Services PA; 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Dath Physician/ Myocard disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of Exami burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death led by the a detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyperlipid emca Division of Vital Records, 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 prior to completion death? autopsy performe certificate 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Matural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Day, Year) 29d. Date sign completed cause of death (Item 23a) (Type Print)

AD 7211 Quarterfield 21061

Registrar DHMH 17 Rev 7/2009

State

DAMIE 40

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 1145 alla 2011 Medical 4a. Facility Name (if not institution, give street) and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Hunt Vallev Maryland Masonic Home 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** .Year) 9<u>22</u> Jan. 3 Courte Pennsylvania Days Hours 1 □ M 2 😾 F 89 223-26-8609 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Baltimore Hunt Valley 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21030 300 International Circle USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 📈 No 2 "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည permit. Page 1 and 2 should be 1 Department of Health and Ments Important: If item 27 is marked (Unk.) Thompson Jeanette (Unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3517 Waverly Drive Fredericksburg, Va. 22407 Sharon Bell / Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Entombren Dulaney Valley Mauso. 11/30/2011 Timonium, Maryland 21. Signature of Funeral Service Licenset 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final End Stage
Due to (or as a consequence of): Physician/ Jeans disease or condition Medical resulting in death) Examiner Vas aller Disea ery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami physician and sthe burial-transit death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyperterson, Hyperlipschein, GERD, Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of C Deffule Colitio. Uno Sepsis has autopsy page death? performed? 1 Yes 2 No After this certificate funeral director, pag Yes 2 DIN **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ٩ To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 29c. License number 11-28-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V ROBERT Beuch St 3108

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Box 68760

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 38220 State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEM BER 25 Ronald N. Ghrist 201 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne RUNDE 5. Social Security Number Sex 1 X M 2 D F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days 3/24/1946 Min. 65 **Director** 212-48-2878 Ohio Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Tes 2 XXVo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 519 Elizabeth Road 21061 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2XXMarried þ should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", If Yes, Give 1 Yes 2XXNo Specify. White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Maryland 21215 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Senior Pipe Layer AA County Dept. Works Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 George L. Ghrist Katherine Mathews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 519 Elizabeth Road Mrs. Terry Ghrist / Wife Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place RI XXBurial 2 Cremation 3 Removal from State Meadowridge Mem. Park 11/30/2011 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Semature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. MMON,3disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner M Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 🖂 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: Other: ပ္ 1 🛮 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 24 hours after death. Funeral Director: A Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 3 🗌 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TENDURNIT out. ALD MORLE 195410-10N MMich 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item if per in g921 12-1-11 vt State of Maryland / Department of Health and Mental Hygiene State Registrar 3822 Reg. No. 20 Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 1 Month Physician/ Day MICHAEL ANGELO GALANTINO, 2.3 2011 9:59 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2010 Kurtz Ave Pasadena Anne Arundel Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8 Date of Rirth (Month, Day, Year) Director 219 42 5127 66 1 X M 2 🗆 F 04 1945 Usual Residence of Decedent Maryland items 23a or 28a-f show ner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 Yes 2 No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2010 Kurtz Ave 21122 U.S.A. Page 1 and 2 should be filed within 72 hours after death in ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Deceden

Armed Forces?

1 ▼ Yes 2 □ No 1966 - If Yes, Give 1970 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. r than "natural", or ite the Medical Examiner 1 🗷 Never Married 2 🗌 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 □ Divorced White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Painter County Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Angelo Galantino, Sr Dorothy Elizabeth Pfanneschlag 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Galantino - brother 2010 Kurtz Ave Pasadena, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview_Crematory 11/25/11 Baltimore, MD Signature of Earner Price Licensee 22. Name and Address of Facility GJ Gonce Funeral Home 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ My coldial Medical resulting in death) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Exami Due to (or as a consequence of) ending physician a Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ò in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not respiting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ellenton 24a. Was an autopsy certificate has page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certificetely filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pendina work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. only one 29b. Signature 29d. Date signed (Month, Dav. Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Highway #800 Gilen Burnie MD 21061 itchie 7310 State Registrar

11-08897 Jeffery Giles Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

fery Giles		1- For State Registrar		ryland /		irtment of <i>tificate of</i>	Health and Death	I Mentai I		Reg. No.	201		38222
Physici dical Exami		Decedent's Name (First, Middle)		EFFRE	Y R	YAN GI	LES		2. Date of De Month Novemb	eath Day er 25, 201	Year		of Death
		4a. Facility Name (if not institution 6204 Lawyers Hill Roa		nd number)		4	b. City, Town, or I Elkridge	ocation of Dea		4c. Cc	ounty of Deat vard	h	
Funeral Director		5. Social Security Number 217 37 5560	6. Sex	18	(In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days		Irs. 8. Date of E	7 199	Forei		State or MD
yns		Usual Residence of Decedent 10a. State 10b. County				Town or Location	on		1+++			10d. In	side City Limits
	Į		Arund	el	Li	nthicu							Yes 2 X No
he Mary 1 or 28a- iffed at	Director	10e. Street and Number 223 Coronet	Drive	3			10f. Zip Code	21090		10g. Citizen	of What Cou	-	
D 21215-0036 ashould be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho astic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was	Decedent E ed Forces? es 2 🛚	ver in U.	If Ye	s Decedent of Hisp es, specify Cuban,	panic Origin? (Mexican, Pue		lo- 14.	Race - Amer White, etc.	ican Indi	
urs after tural", aminer	δ	3 Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes, Giv or Dates: cify only highes		leted)	16a. Decedent	Yes 2 X No	on (Give kind o			ecify: W	nit∈ (Industry	2
3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Deceded during 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent during 17a							ost of working life. Denter	DO NOT use r	etired)	A&M	Dive	rsi	fied Co
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2121 thould be find Mental is marked atic event,	To E	19a, Informant's Name/Relations	hip (Type, Print)	LOTTE	19b. Mailing	Address (Street	and Number o	r Rural Route N	umber, City o	or Town, State		
≥ 2 5 2 3		Karen Cole -				lace of Disposi	Coronet		Linthio Date		MD Z ation - City or	109 Town, \$	
Baltimore, permit. Pages 1 and Department of Heal Important: If iten injury or other tra		1 Burial 2 Cremation 4 Donation 5 Other Sp	ecify:	val from State	' I	rematory or oth	Cremato						
Ball permit Depart Impor injury		169 Riviera Dr							J Gonc	e Fur asade	neral na. M	Hon ID	ne, PA 21122
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.		e death.								oximate Interval reen Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		as a conseq	uence of	f):							1
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or	as a conseq	uence of	f):							
uted nd ransit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or	as a conseq	uence of	f):							
50, te be executed ysician and burial - transit	edical	UNPENDED	X AMEND	ED 28d	per	me g92	4 2-16-1	2 vt					
cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and should be detached for use as the burial - transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Univ	1 L 4 F	yes, outcome ive birth regnant at tir		2 Fet	al death 3 [ner (Specify)	Ectopic preg	nancy		ate of deliver onth	y Day	Year
O. Bc at the dea		Part II. Other significant conditi	a	Inknown ing to death b	out not re	esulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use	contribute to	the cau	se of death?
brds, P.O. w requires that the state of the	ted by								_ 1 ☐ Y 24a. Wa				Unknown
n of Vital Records, the Physician: The law require After this certificate has been si funeral director, page 2 should b	Completed								aut per	opsy formed? 2 No		completi	on of cause of
Vital hysician: this certif	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2	ER/Outpatient		of Death (Chee Other Nur	sing Home 5	_	_		
	Certification:	3 Suicide 6 Coul	ling FOI Nov d not be		r) ry - At ho			y at Work? es 2 ✓ No uilding, etc.		ixed obj ixed o (Street and	bject Number or Ri	on- coll ural Rou	
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: completely filled in by the fi	Medical Cer	29a. Certifier 1 Certifying Pt	nysician: To the	asis of exami	nowled	ge, death occurr	red at the time, dat			use(s) and m	nanner as sta	ted.	(s)
To To com	Med	29b. Signature and title of certifie		ner stated.			29c. License				te signed (Mo		r, Year)
0.1/		30. Name and address of person	who completed	cause of dea	th (Item	23a)	O.C.N	1.E.		Noven	nber 26, 2	011	
かく		Ling Li, MD Assista	nt Medical I	Examiner	900	W. Baltimor	e Street, Balti	more, MD	21223				
St	tate	31. Date filed (Month, Day, Year)	3	2. egistrar's	Signatu	7	.00						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death November 27 (201 ham **Physician** quer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M Yrs. Director 218-34-0049 July 25,1925 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 ¥ Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1313 N. Caroline St. 21213 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No ģ Specify 3 ⊠ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Private Homes 8th 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Clark မ Viola Holcombe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If Item 27 is any Injury or other trau once. Diane Austin (daughter) 1313 N. Caroline St. Balto, Md. 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt.Zion Cemetery Dec.8,2011 Balto, Md. 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home 21. Signature of Paral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Balto,Md. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease Atheroscierotic disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and is the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death Live birth 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Division of Vital Records, P.O. he 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s certificate has director, page ? performed' 2 No 2 No or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA ၉ 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury ours after death.

leral Director: Aft
filled in by the fu 1 Tyes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JALALI mi 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure Ali Copies Are Legible.

Vilgina Hill		State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg. No.	322
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death	:h
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hespital 4c. County of Death Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 1 M 2 F Usual Residence of Decedent	
land f show any once.	tor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City	
hours after death with the Maryland natural", or items 23a or 28s-f sho Examiner must be notified at once.	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11g. Was Decedent Ever in U.S. 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- 11g. Race - American Indian, Black 11g. Was Decedent Ever in U.S. 11g. Was Decedent of Hispanic Origin? (Specify Yes or No- 11g. Race - American Indian, Black White, etc.	k,
2 3	Completed by F	3 Wildowed 4 Divorced in res, Give Year or Dates: 1 Yes 2 No specify: Specify: Specify: Jack 45 Deceded to Education (Specify College) In the Property of Dates: 15 Deceded to Education (Specify College) In the Property of Dates:	
21215-0036 uld be filed within 72 Mental Hygiene. marked other than "	a	Marilla Las Hill	
, MD and 2 sho ealth and cm 27 is	<u>م</u>	19a. Informan's Name/Relationship (Type, Print) Power 19b. Mailing Address (Street and Number or Rural R. te Number, City or Town, State, Zip Code) No. 19b. Mailing Address (Street and Number or Rural R. te Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural R. te Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural R. te Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural R. te Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20c. Location - C	8
Baltimore permit. Pages 1: Department of H. Important: If it		4 Donation 5 Other Specify: 21. Signified of Funeral Service License 22. Name and Address of Ficility Rus Funeral Home P.A. 23. Signified of Funeral Service License 22. Name and Address of Ficility Rus Funeral Home P.A. 23. 23. W. North Ave. Balto. MD 21	0./
Physician /Medical Examiner		23a. Part I. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Est only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate In Between Onse Death Due to (or as a consequence of):	nterval et and
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.	
0, be executed sician and ourial - transit	edical Exa	events resulting in death) Last Due to (or as a consequence of): d. AMENDED 23a,27,per me,g922 12-16-11 sm	
certificate adding phy lise as the b	ΣI		ar
P.O. B is that the de gned by the	by Phy		
	Completed	24a. Was an autopsy findings average prior to completion of cause performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2	ailable
Vital Rebysician: The this certificate	o Be	25. Was case referred to medical examiner? 1 Yes 2 No No No No No No No No	
ion of vertient of the funeral	ation: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)	r, City
Divi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
3.0	2	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) November 28, 2011	
9/6		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
St: Regist	-		

DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38225 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death UMUNDCR **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Jan. 23, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2XXF Months Yrs Jan. 407-76-6141 60 1951 Kentucky **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or one any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Md. N/A Baltimore City 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2901 Boston Street #510 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No þ 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 16b. Kind of Business/Industry Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore Elementary/Secondary (0-12) College (1-4 or 5+) 4 Executive Director **Alliance** Cultural 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert M. Haragan, Sr. A1ma Lee Gaynor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwen Davidson/Partner 2901 Boston St. #510 Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 11/30/11 Towson, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, see in each line 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can Approximate Interval Between Onset and Death cause Immediate Cause (Final Physician disease or condition resulting in death) as a consequence of) Sequentially list conditions, if an, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence of) Due to (or as a consequence of) Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 \sum Live birth 2 \sum Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy page 2 should be detached for Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Vunknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed 1 Tes 2 2 🗌 No within 24 hours after death.

To the Funeral Director; After this certifical completely filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 No 1 Inpatient ၉ 2 ER/Outpatient 3 🗆 DOA 28d. Describe how injury occurred

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed ician and burial-trans attending physician Division of Vital Records, P.O. Box 68760 signed by the

Certification:

Medical

State Registrar

(check only

one)

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide

6 ☐ Could not be 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28a. Date of Injury (Month, Day Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of Injury

28c. Injury at Work? 1 Tyes

2 🗀 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 90

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

60

the Hospital

Shan 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2011

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 38226 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 3:35 Glenn William Hardy 2011 A^{M} November Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Towson Gilchrist Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 213-30-5827 January 6,1932 1 🕅 M 2 🗆 F 79 Maryland **Director** 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 🗆 Yes 2 ื No be notified Hydes |Maryland| Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò 21082 23a Funeral United States 4813 Long Green Rd. must items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Medical Examiner Armed Forces Black, White, etc 1 Never Married 2 X Married "natural", or by 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white If Yes, Give Year or Dates.1955–56 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) commercial glass and Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) metal/subcontracting the company president and Mental Hygie is marked other injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) |George Alvin Hardy Helen Fody 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important If item 27 is any injury or other trau Hydes, MD 21082 P. O. Box 66 Helen A. Hardy/wife Page 1 and 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Green Mount Crematory | Dec. 1, 2011 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Witchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ADVANCEP DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed -tran and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 as the I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? Month Year 5 Other (specify) n signed by the a Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTONSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably OPPRESSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsv Director: After this certificate has perform death? Hospital or Attending Physician: 24 hours after death. completely filled in by the funeral director, 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 5 Pending 1 Aatural 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifie happes Street BALTIMORE MD 2/204 State DEC 0 1 2011 Registrar

11-08904 Sophia Hamilton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2011	3822
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		For State			Cen	tificate of	Death			Reg.		0 1	1 0022
Physician/	/ 1	. Decedent's Name (Fi	rst, Middle,Last)				_		Mor	e of Death nth D	ay Year		3. Time of Death
Modical Examine		SOPHIE		LENA		HAMILTO		Landina		ember 2	4c. County o	(Death	1040 hrs
	4	 Facility Name (if not Sinai Hospital 	institution, give	street and numbe	r)	14	o. City, Town, or Baltimore	Location of	Death			Death	
Funeral	5	. Social Security Numb	er 6. Sex	17. A	ge (In yrs. la	st birthday)	If Under 1 Yea	ar If Under	24Hrs. 8. Da	ate of Birth	N/A MM/DD/YYYY	9. Birth	place (State or
Director		•		M 2XF			Months Day	s Hours	Min.	(1021	1002	Foreign Cour	ntry) MD
	_	216-39-082 Isual Residence of Dec		VI 2 1		18 Yrs.	<u></u>		1 10	6/03/	1993		MD
any	_		County		10c. City,	Town or Location	on						10d. Inside City Limits
show store	-	DC	WASHING'	TON	WAS	HINGTON							1 X Yes 2 No
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th the Maryland 23a or 28a-f sho notified at once.	5	4412 15TH	STREET	NW			20011						USA
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or ite		1 X Never Married		1 Yes	2 X No		<u>v</u>				Specific		_
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5-0036 led within 72 hours af lygiene. other than "natural the Medical Examin Completed by	<u> </u>	Elementary/Seconda		College (1-4 o			st of working life						
336 hin 7. than edical		12	^ ′				STUDEN	JT			S	TUDE	ENT
5-00 ed wit tygien offer offer Con	3 1	7. Father's Name (Firs	t, Middle, Last)						s Name (First,	Middle, Ma	iden Surname)		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		WAYNE				HAMILTO	ON	SHAR				BENZ	
more, MD 21215-0636 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygene. ant: If item 27 is marked other than "natural", or items 23a or 28a-fabt are other traumatic event, the Medical Examiner must be notified at once TO Re Completed by Funeral Director	2 1	9a. Informant's Name/					Address (Stree						
nore, MD 2 ages 1 and 2 shou nt of Health and N t: If item 27 is n other traumatic	L	SHARON BE		THER	20h P		15TH ST		NW, WAS		ON, DC 20c. Location -		
Baltimore, M permit. Pages I and 2 Department of Health Important: If iten 2 Injury or other traus	_	1 X Burial 2		Removal from S	State C	rematory or oth	er place)						
timent that:	L	4 Donation 5			BA		E HEBREW	s of Eacility	11/30/	2011	REIST	ERST	TOWN, MD
Balti permit. Departm Imports injury o		1. Signature of Funera	ii Service Licens			22.1	ame and Addres		SOL LE	VINSO	N & BRO)S.,	INC. MD 21208
Physician	2	8900 REISTERSTOWN ROAD, PIKESVILL 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									art	Approximate Interval	
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ted Insit		f any, leading to immed cause. Enter Underlyir	ng Cause	ue to (or as a con	sequence of):							
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3760, ificate be g physici s the buri		F FEMALE: 3b. Was decedent preç	nant in the	23c. If yes, outo	ome of pregr	-	al death 3	Ectopic	pregnancy		23d. Date of Month	delivery Da	ay Year
Box 68's e death certification at the attending ed for use as it	5	past 12 months?			at time of dea	oth -	er (Specify)						
by the attending cheed for use as!	Z Z	1 Yes 2 No 9		9 Unknown						On Distant			he cause of death?
that the death certification by the attending detached for use as the Dhysician		Part II. Other significa		contributing to de	ath but not re	esulting in the u	nderlying cause	given in Par					ably 4 V Unknown
Records, P.(The law requires that ficate has been signed , page 2 should be determinated by		Pneumonia	<u> </u>					-		4a. Was an			opsy findings available
ord ord w reg as bee shou							-			autopsy	P		ompletion of cause of
Rec The la	Ę								1 [✔ Yes 2	No 1	✓ Yes	2 No
ician: certifi rector,		25. Was case referred examiner?		ospital: 1 Inpa					Check only on			70,,,,	
Physic ral dire	o L	1 Yes 2	No	28a. Date of Ir		ER/Outpatient 28b. Time of Ir		ury at Work			esidence 6 _		
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the start death. **In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted by P.	<u></u>	4 🗆	Pending	(Month, Day	Year)	_	1-1-	Yes 2		known	• •		
Sional Attentant de		2 Accident	Investigatio	28a Place of		fd 10:0	t, factory, office		c. 28f. L				al Route Number, City
Division of Vital Records, P.C. spital or Attending Physician: The law requires that usral Director: After this certificate has been signed filled in by the funeral director, page 2 should be determed in by the funeral director, page 2 should be determed in by the funeral director, page 2 should be determed in by the funeral director, page 2 should be determed in by the funeral director, page 2 should be determed by		3 Suicide 6 4 Homicide	Could not be determined		nund i	n bouse						eenw	rich P1.
E me me me											as state	d.	
To the How within 24 h within 24 h completely		one) 2 Me	dical Examiner:	On the basis of ex and manner state	amination a	nd/or investigat	on, in my opinio	n, death occ	curred at the ti	me, date ar	nd place, and d	lue to the	cause(s)
E 3 E 3	Ž 2	29b. Signature and title		1	17			se number			29d. Date signe		
			7/	W1, /			O.C	.M.E.			November	27, 20	11
by pend	3	30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											
V		Jack Titus MD			rar's Signatu			eei, Baiti	miore, IVID	Z 1223			
∦ Stat Registra	te ^s ar	31. Date filed (Month C	C 0 1 20	32. Regist	un s signatu	3. pa	Kel						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jeorse W. Harvey 06/5AM Notem ber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital of Baltimore Sinai Baltimore utr N/A Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 📭 2 🗆 F Months Days Hours 05703/1984 Maryland 214-06-1828 27 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified MD N/A Baltimore 1x Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 2008 Woodlawn Dr. Apt I 21207 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify "natural" Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) 11th Grade College (1-4 or 5+) unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental t ည George W. Harvey Sr. Shirley L. Century 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Shirley Century (mother) 2008 Woodlawn Dr. Apt I, Balto., MD21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Western Star Cem. 11/30/11 Baltimore, MD 21. Signature of Funeral Service License Joseph Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 hichI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Gastrointertinal Physician/ 61669 disease or condition da Medical resulting in death) Due to (or as a consequence of): Examiner 27 reals Sickle cell anemia Sequentially list conditions If any, leading to immediate cause. Enter Underlying Examir nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ End state 415645C Division of Vital Records, renal 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar Hospital or Attending Physician; The law 1 24 hours after death.
 Funeral Director: After this certificate has b has e 2 autopsy performe 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) Sillie MD Res - 000 November 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUNNEE PAVE MD SINA) 11 sunnee sindi MOPHAI Baltimore

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38229 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Catherine C. Imbach 5:30 PM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Catonsville St. Joseph's Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 212-10-8343 1 □ M 2X ☐ F Dec 25, 1915 95 Maryland Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Medical Examiner must be notified at Director 1 🗆 Yes 2🎾 No Ellicott City Marvland Howard the 1 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 3735 Cross Bow Court 21042 **USA** within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie O'Neill Edward Cusack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3735 Cross Bow Court Ellicott City, MD 21042 Important: If item 27 Richard M. Imbach, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 and Department of F any injury or conce, 1 Marial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) 11/30/11 Baltimore, Maryland New Cathedral Cemetery Signature of Funeral Service Licensee Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical equeno Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 I 27. Manner of Death 1 ☑ Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending eral Director; A 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Cartifying Nurse Practitioner: To the best of my knowle 2336 Jovenber 22, 2011 ted cause of death (Item 23a) (Type, Print) 405 Registrar

2011

DHMH 17 Rev 06-2011

State Registrar TRACIE L. MORGAN, CRNP

2300 DULANEY VALLEY RD.

32. Registrar's Signature

TIMONIUM.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3823 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ KDLACKI HELEN ovember 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown orthwest Baltimore HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2**X**□ F Days 053-26-457 78 Director DC Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland 10d. Inside City Limits Director MD Randallstown Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5412 Old Court Road USA 2113 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: Caucasion Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Onl<u>ine worker</u> 12th Grade NA Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Casmir Kolacki McAllister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,{
m MD}\,$. Terry Sullivan-Guardian N. Calvert Street Suite #200 Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Metro Crematory 12-02-11 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore,MD 21217 23a Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Sepsis disease or condition Medical resulting in death) **Examiner** neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 4 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\tint{\text{\tinte\text{\tinit}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texiext{\texi}\text{\text{\text{\texi}\text{\text{\text{\text{\text{\texicr{\texi}\text{\text{\text{\tin\text{\text{\text{\text{\texi}\text{\text{\texi}\text{\text{\t 2 4 No 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending injury 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier November, 30, 2011 Loun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Abdallah Kafroun, 5401 Old Court Road, Randallstown; HD 21133 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38232 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <u>2011</u> BERNARD FRANCIS KAMINSKI, SR. 10:10 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Min 93 Director 216 09 2090 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 7636 Beach Drive U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗆 No 1944

If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 X Widowed 4 ☐ Divorced Completed 1945 White Year or Dates the Medic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.
7 is marked other than "r traumatic event, the Med Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) 10 Gas Fitter Gas and Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be ont of Health and Menta it: If item 27 is marked y or other traumatic e Walenty Kaminski Pelagia Sroka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 309 Eva Ave Bernard Kaminski, Jr.- Son Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 12 2 2011 Rosedale, 21. Signature of Euneral Sovice Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, 169 Pasadena, MD Riviera Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MeTa disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and s been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 XXX 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💆 No Hospital 1 \square Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of g 6×11 person who completed cayse of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 28 2011 Physician/ 03:00A M KUPERMAN CYNTHIA Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE BALTIMORE 704 SUDBROOK ROAD Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 215-30-4977 **Director** 1 □ M 2 🗶 F Yrs NY 76 03/20/1935 Usual Residence of Decedent 10d. Inside City Limits items 23a or 28a-f show 10c. City, Town or Location 10a, State 10b. County filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21208 704 SUDBROOK ROAD Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced WHITE other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT LEGAL 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ CHAIET GUSSIE FRANK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 704 SUDBROOK ROAD, BALTIMORE, MD 21208 LEE KUPERMAN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 11/30/2011 FINKSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CONG. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 month Day Year 5 Other (specify) Pregnant at time of death page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performe 1 Yes 2 No Yes 2 : After this certifica e funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) <u>|</u>e 28a. Date of injury (Month, Day, Year) 27. Manner 28b. Time of 28d. Describe how injury occurred eath 28c. Injury at Certificate: iniury work? 5 Pending atural ours after death, leral Director: Aft filled in by the fur 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar 3

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schrnede

29c, License number

29d. Date signed (Month, Day, Year)

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2011 1:59 AM M November 24, Betty J. Linnbaum Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1966 Poplar Ridge Road Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year **Funeral** 1 🗌 M 2🗶 F Days (Month, Day Year) Dec. 26, 1925 85 **Director** Maryland 220-22-9802 Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 Ves 2 No Maryland Anne Arundel Pasadena 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? traumatic event, the Medical Examiner must be Funeral 23a USA 21122 1966 Poplar Ridge Road or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 XWidowed 4 Divorced SpecifWhite Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Household Homemaker 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important. If item 27 is marked of any injury or other traumatic ew မ Viola Albert Vernon Care 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane M. Linnbaum Daughter 1966 Poplar Ridge Road Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State etery, crematory or other place) Nov 29 Elkridge, MD 4 ☐ Donation _ 5 ☐ Other (Specify) Meadowridge Cemetery 2011 Signature Funeral Service Lige 22. Name and Address of Facility
Stallings Funeral Home, P.A. 3111 Mountain Road Pasadena Maryland 21122201 23a. Part f. Enter the disease, or complications that cau shock, or heart failure. List only one cause not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IE FEMALE ves, outcome of s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death Yes 9 Unknown g Unknown P.O. contributing to death but not resulting in the underlying cause given in Part I. Other significant condition 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Tes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autops 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: Nο |은 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this Man ner of De 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only or 29b. Signatur

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 4:40 PM **Physician** 5 5 18 201 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Catonsville Catonsville Commons Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) April 19,1935 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Sex 1 → M 2 □ F **Funeral** Min. Months Days Hours North Carolina Yrs 243-48-2837 76 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a, State or 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, its Medical Examiner must be rediffed at 1 □Yes 2 □ No Director Baltimore Catonsville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or USA 21228 6 Arbutus Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11. Marital Status 1 Never Married 2 Married White 1 □Yes 2 No Specify Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paper Mill Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Etta May Grant Thomas Luther Long ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Heath ar Important: If item 27 Is any Injury or other trau. Arbutus Avenue, Catonsville Maryland 21228 Margaret Long-Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Nov. 25 2011 Glen Burnie Maryland Atlantic Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral frome Of Lansdowne 21. Signature of Funeral Service Licens 2719 Hammonds Ferry Road Lansdowne Maryland 21227 200 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months Physician STY CI /Medical (or as a consequence of): Duc ty xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year in the past 12 months? 1 ☐Yes 2 ☐ No P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 🗆 No 2 2 1 ☐ Yes certificate 1 ☐ Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, director, Be Other: Hospital: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient this Certification: To 28d. Describe how injury occurred After th funeral 28b. Time of 27. Manne Death 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) Iniury 5 Pending investigation 1 atural 1 ☐ Yes 2 ☐ No n 24 hours after death.

Ie Funeral Director; A

Jetely filled in by the fu death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide determined 4 Homicide 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely within 2 29d. Date signed (Month, Day, Year) License numbe who completed cause of death (Item 23a rater Colony 31. Date filed (Month, Day, Year)

DEC 0 1 201 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

11-08490	
Evelyn Lewis	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

n Lewis		Sta 1- For State Registrar		Cer	uncate or	Death		F	Reg. No.	0 1 1	382
Physici cal Exam		Decedent's Name (First, Middle,						2. Date of De Month	ath Day Ye er 11, 2011	or I	me of Death 310 hrs
		4a. Facility Name (if not institution,	-	ber)	4	4b. City, Town, or L	ocation of De		4c. County	of Death	
		Harbor Hospital Center				Baltimore N/A If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or					101
Funeral Director		219-66-6590	5. Sex 7.	. Age (In yrs. Ia	sst birthday) 55 Yrs.	Months Days	If Under 24 Hours	Min. 9/9/1	,	Y) 9. Birthplace Foreign Country)	e (State or MD
any.		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	ion				10d.	Inside City Limits
*	5	MD N	/A	Ва	altimore	9				1 🗵	Yes 2 No
permit pages I and Stould be filed within 72 hours after death with the Maryland Operaturent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatie event, the Medical Examiner must be notified at once	Director	10e. Street and Number 2119 Annappolis	s Rd.			10f. Zip Code 21230			10g. Citizen of W USA	hat Country?	
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By Physician: The law requires that the death certificate be executed managed by the attending physician and managed by the attending p	Certification: To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or confailure. List only one cause or failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LINPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown Part II. Other significant condition End—Stage rena 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin Investig Suicide 6 Could in Unvestig Suicide 6 Could determ Check only one) 2 Medical Examiner 29a. Certifier Certifying Physical Physical Could in	Due to (or as a composed by the composed by th	morphiconsequence of consequence of	Do not enter the ine int. ine int. ine int. ine int. inc. inc	a-f,per material death 3 and death 4 and d	Death (Chethera Nuat Work? S 2 No ROWN and place, an	2 12-2-1 gnancy 23e. Did 1 1 Ye 24a Was auto perfor 1 28d. Describe Subject 28f. Location or Town, Baltime and due to the caused at the time, date	Date of Month 23d. Date of Month 23d. Date of Month 23d. Date of Month 24b. 10 27 No 1 Residence 6 how injury occur 2 took d Street and Numb State) 2119 Dre, Md. se(s) and manner and place, and c 29d. Date sign	rugs er or Rural Roc Annapol as stated, due to the caused (Month, Da	Year Vear Vear Unknown findings available tion of cause of No Vear

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20:25 20 2011 Medical Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memoria timore Birthplace (State or Foreign Country) If Under 1 Age (h vrs. last birthday) 8. Date of Birth **Funeral** Min Director JO & Th Usual Residence of Decedent 28a-f show 10a. State 10b. County 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 ☑Yes 2 ☐ No 10e. Street and Number ò 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. Yes 2 No ò 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 M No 3 ☑ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) ۵ ttome Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည iams 19a. Informant's Name/Relationship (Type, Print) (Daughtur) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service Licensee 3 or 23a. Partyl. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asprationpheyronia Physician/ disease or condition resulting in death) weeks Medical Due to (or as a consequence of): **Examiner** Preumococcal week Phily mouro Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 2 **X**No 25. Was case referred to medical 26. Place of Death (Check only one) 1 \(\text{Yes} 2 No 1X Inpatient 2 🗆 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural Accident 5 Pending Investigation 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ATZ438946-DI8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway, Baltimore MD 21218 agu 201 E. University 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Approximate Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 -NO 1 Tyes completed filled in by the funeral director, 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29b. Signature and title of certifier D69540 2011. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2123/ CS13 Wellan 204 Jigar. Shah 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

MO

10d. Inside City Limits

1 Yes 2 No

201

5:45P M

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38239 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 23, 2011 Physician/ 6:30 A M Monahan Regina Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore Mercy Villa If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5, Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Months Days Hours 1171671928 Massachusetts 83 Director 017-22-2657 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-6-100c. any injury or other traumatic event, the Medical Francisco. 10d. Inside City Limits 10c. City, Town or Location 10b. County Director 1 🗆 Yes 2 💆 No Maryland|Baltimore Stevenson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral U.S.A. Greenspring Valley Road 21153 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Education College (1-4 or 5+) Teacher 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Regina McGee Alphonsus George Monahan Religious 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21153 19a. Informant's Name/Relationship (Type, Print) 1531 Greenspring Valley Road Stevenson, Maryland Sr. Patricia Hoeflich /Sister 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Ellicott City, Maryland Ilchester Cemetery 11/30/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ementic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 1 ☐ Yes 2+5 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗆 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မြ within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27 Manner of Death 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at its visual state. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Coctifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of cenifier License number 29d. Date signed (Month, Day, Year, 25/11

Registrar DHMH 17 Rev 7/2009 101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHMOUN

31. Date filed (Month, Day, Year) DEC 0 1 2011

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** 2011 28 McDermott Michael Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Himore N/A University Specialty Hospital 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days Hours 056-44-6689 July 19,1952 59 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Phoenix 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21131 U.S.A. 2818 Paper Mill Road Funeral Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Mamied 1 ☐ Yes 2 No Specify White 2 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ McCormick & Co. Vice President- Sales Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dienges McDermott June Martin Joseph ပ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Phoenix, Maryland 21131 2818 Paper Mill Road Wife Marilyn McDermott 20b. Place of Disposition (Name of Dulaney Valley Memorial Gardens 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland 12-1-2011 Timonium 4 □Donation 5 □ Other (Specify) 21. Signature of Fun val Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 lai 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final Anoxi **Physician** disease or condition resulting in death) 6 months Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consiquence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760. Physician/Medical If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 I Inknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 □ No 2 X No 1 □ Yes SACYA 25. Was case referred to medical examiner?
1 ★ Yes 2 No 26. Place of Death (Check only one) Be Other: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After t Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 15V State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aura Marshall		State of Maryland / Department of State of Maryland / Department of Certificate of Registrar		ygiene _{Reg.}	201	1 3821
Physicia		Decedent's Name (First, Middle,Last)		Date of Death Month	av Year	3. Time of Death
Medical Exami	ner	Laura Marshall 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	November 2	3, 2011 4c. County of Death	0636 hrs
		Baltimore Washington Medical Center	Glen Burnie		Anne Arundel	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 218-88-0171 1 M 2 X F 40 Y	If Under 1 Year If Under 24Hrs Months Days Hours Min.		MM/DD/YYYY) 9. Birth Foreign Cou	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Loc	ation			10d. Inside City Limits
	_	MD Anne Arundel Co. Glen Bur			1	1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	ry?
ith the Maryland 23a or 28a-f sho notified at once.	Ö	311 Henson Road	21060	Un	ited State	S
th with	Funeral		Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
hours after death with the Maryland hatural", or items 23a or 28a-f she Examiner must be notified at once		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 X No specify:		Specify: Whi	te
ours aff	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	ent's Usual Occupation (Give kind of v		6b. Kind of Business/In	
6 72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use retir	red)		
15-0036 filed within 72 1 Hygiene. ed other than "	omo	12 Med 17. Father's Name (First, Middle, Last)	dical Secretary		Healthcare	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; injury or other traumatic event, the Medical Examiner	Be C	Clifford Walter Marshall		(First, Middle, Mai	urner	
AD 212 2 should be h and Menta 27 is marke matic even	ם		ing Address (Street and Number or R			Zip Code)
MD nd 2 sh alth an				insburg,		
Baltimore, permit. Pages 1 an Department of He Important: If ite		20b. Place of Disposition 1 Burial 2 Tornation 3 Removal from State crematory or company or compan	osition (Name of cemetery, other place)	Date 2	Oc. Location - City or T	own, State
timent rtment y or o		4 Donation 5 Other Specify: Atlantic 21. Signature of Fuperal Service Dicen 22.	Crematory 12/0	01/2011	Glen Burni	e, MD
Balti permit. Departm Importa		M01121 Se	Name and Address of Facility Sirervices PA; 1 2nd	ngleton F	uneral & C Glen Burni	remation MD 21061
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac or	r respiratory arrest,	, shock, or heart	Approximate Interval 8etween Onset and
/Medical ≟xaminer		Immediate Cause (Final disease a. Complications of Obesity				Death
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Box 6876(e death certificate the attending physe	Sicial	past 12 months? 4 Pregnant at time of death 5	Other (Specify)		9	,
C. Boy tructedeath by the att	Physi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did toba	cco use contribute to th	a cause of death?
ires that the signed by I be detach	盃	Solution of the second	and onlying dadde given in Fait i.		2 No 3 Proba	
cords,	Completed			24a. Was an		psy findings available
eco he law tte has	ğ			autopsy performe 1 ✔ Yes 2		mpletion of cause of
Vital Rec ysician: The I his certificate I director, page	Be	25. Was case referred to medical	26.Place of Death (Check of			
Vita	일	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatier			sidence 6 Other:	
Division of Vital Records, ral or Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be		27. Manner of Death 1 ✓ Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of	f Injury 28c. Injury at Work?	28d. Describe how	injury occurred	
isior Attender death	gati	2 Accident Investigation 28e Place of Injury - At home farm stru		28f. Location (Stre	et and Number or Rura	Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, State		
	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investign and manner stated.				
E > E 8	ž	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Monti	h, Day, Year)
		MI COM	O.C.M.E.	N	lovember 24, 201	1
\		_) W. Baltimore Street, Baltim	ore, MD 21223	3	
Sta Registi	ite rar	31. Date filed (Month, Day, Year) DEC 0 1 2011 Certain 32. Registrar's Signature A and a second s	*			
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Amir Carnell Miles-Humes	State of Maryland / Department of Hea

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5-0036 ed within 72 hours after death with the Maryland lygienc. The Medical Examiner must be notified at once. Completed by Funeral Director	Anthony C. Hume	#B1 12. Was Decedent Ever in Armed Forces? 1	ty, Town or Lo	4b. City, To Baltim Part of Months 10f. Zip 0 Was Deceden If Yes, specify Yes 2 gedent's Usual City of work wm, or Local ore 1 Year If Days F Baltin Code 2122 t of Hispani Cuban, Me	25 ic Origin? (S exican, Puerto pecify:	8. Date of Birth 06/19/	4c. County of (MM/DD/YYYY) 1985 g. Citizen of Wr USA	9. Birthplace (State or Foreign Country) New York 10d. Inside City Limits 1 X Yes 2 No hat Country? A e. American Indian, Black, e, etc.		
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imore, MD 21 Pages 1 and 2 should ment of Health and Me tant: If item 27 is ma or other traumatic ev	Jacquelyn Miles 20a. Method of Disposition 1 Burial 2 X Cremation 3	(Mother)	63°		y Glo	w Cour	t, Colum	nber, City or Town, State, Zip Code) nbia, MD 21045 20c. Location - City or Town, State		
Baltimore, MD permit. Pages 1 and 2 sh Department of Health and Important: If item 27: injury or other transman	4 Donation 5 Other Specify: 21. Signature of Funeral Service Lice	A	rdent	Cremati 22. Name and A	Address of F	Facility Lat		neral S	Hanover, MD eral Services, PA Baltimore MD 21224	
/Medical Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ch line. Intra-oral Gunshot Wi Due to (or as a consequence Due to (or as a consequence	ound of):						Between Onset and Death	
execution and all - tra	events resulting in death) Last UNPENDED	Due to (or as a consequence	e of):							
). Box 68760, the death certificate be by the attending physicisched for use as the buring Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown						of delivery Day Year		
s, P.O. I nires that the n signed by the d be detached	1							Oid tobacco use contribute to the cause of death? Yes 2 ✓ No 3 ☐ Probably 4 ☐ Unknown		
of Vital Records, s Physician: The law requires then this certificate has been sig- neral director, page 2 should be n: To Be Completed							autops perform 1 Yes 2	sy med?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
of Vital Rec Physician: The Prysician: The Prysician: The Prysician: The Prysician To Be Con	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	lospital: 1 Inpatient 2		atient 3 D			ing Home 5 i			
sion vitendir death.	1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not determine	on be Place of Injury - A	FOUND 1815 hr): s		2 ✔ No ding, etc.	Subject shot 28f. Location (S or Town, S 2204 Round R	Street and Numb	ber or Rural Route Number, City ore, MD	
Divisi To the Hospital ar Att within 24 hours after d. Tha the Funeral Direct completely filled in by	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examiner	lan: To the best of my know cOn the basis of examinationand manner stated.	ledge, death on and/or inve	stigation, in my	opinion, de	eath occurred	nd due to the caus	and place, and	due to the cause(s)	
×	29b. Signature and title of certifier	it	tom 22 a)	290	O.C.M.			November	r 26, 2011	
State	24 5 5 10 10 10 10	completed cause of death (I' Chief Medical Examil 32. Registrar's Sign	ner 900	W. Baltimo	re Street,	, Baltimor	e, MD 21223			

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar 38243 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 Nov.28 11:30A M McClellan Alice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospic Care, Inc. Towson nder 1 Year I If Under 24 Hrs. If Under 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 6415-1921 100-90 yrs. 219-86-3725 **Director** 1 □ M 2 🕱 F MD Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location Director notified 28a-f Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 23a 21213 2012 N. Wolfe St. USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. ō 1 X Never Married 2 ☐ Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the N/A unknown Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve once. ပ unknown Edna Bowie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2012 N. Wolfe St. Balto, Md. 21213 Fannie Wiggins (Caregiver) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date GreenMount Crematory Nov.30,2011 1
Burial 2 Cremation 3 Removal from State Balto, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature ice Licensee Calvin Address of Scruggs Funeral Home Ε. Preston St. Balto, Md. 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OF UNKNOWN PRIM MONTHS CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a nonsequence of) burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mo Year Month Day Pregnant at time of death 1 Yes 2 de Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 24b performed Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner Death 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral Direct Funeral Direct Place In Direc Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) 30. Name ar address of person who 31. Date filed (Mor State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. of Mandand / Department of Health and Mental Hygiene

		4	For State	State of M	aryland	I / Depa	rtment of F	lealth and	d Mental Hy	·		38244	
			Registrar 1. Decedent's Name (First, Middle, L	ast)	_	Cer	incate of L	Jeani	2. Date of Dea	Reg. No.	Van	3. Time of Death	
	Physicia Medic		GRACE MIL	chell					Month	22/	2011	1215 P M	
	Examin	er	4a. Facility Name (if not institution, g	ve street and number)	2660	h	4b. City, Town, or	Location of De	ath	4c. Coul	nty of Death		
	Funeral Director				e (In yrs. las 92		If Under 1 Year Months Days	If Under 24 H Hours Mi		th y Year)	9. Birth; Coun	place (State or Foreign try) PA	
	how at	l. h	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation				1	0d. Inside City Limits	
	Marylar 18a-f sl	Director	MD N/A		Bal	timore						1 X Yes 2 □ No	
	with the 1 23a or 2 ust be no		10e. Street and Number 5503 Sinclair Greens	Drive			10f. Zip Code 21206			10g. Citizen	of What Cour	ntry?	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any righty or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2	Ever in U.S. No	If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	ın, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		Race - Americ Black, White, bify: Bla	etc.	
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121	d withi	l as l	12th 17. Father's Name (First, Middle, Las	N/A		Litera	ture Evang		Name (First, Middle,			ve icisc di•	
lanc	I be file fental H rked o tic eve	10 [William Howard	54					sta Stokes				
Mary	12 should alth and M 27 is ma r trauma'		19a. Informant's Name/Relationship Bernadine Woods-Daugh			19b. Mailir 5503 S:	g Address (Street inclair Gre	and Number or ens Driv	Rural Route Numbe e Baltimore	er, City or Town	n, State, Zip 06	Code)	
Baltimore, Maryland 21215-0036	Page 1 and nent of Hes ant: If item ary or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp.	Removal from State	, ce	ace of Dispo metery, cren ity Cem	sition (Name of natory or other place etery	ce) 111/	Date 30/2011	20c. Location	on - City or T	own, State	
Balti	permit. Departr Importa any inju		21. Signature of Funeral Service Lic	ensee .			. Name and Addre		March F/H l	101 E. N	iorth Av	e•	
			23a. Part . Enter the disease, or c shock, or heart failure. List on	omplications that cause ly one cause on each lin	e.				diac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	the state of the s		DEMENT	FIA				Onset and Death	
	Examiner		Sequentially list conditions	b Bue to (or as	a conseque	31100 017.							
	sit sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as	a conseque	ence of):							
	e be executed ysician and e burial-transit	Еха	that initiated events resulting in death) Last	c. Due to (or as	Due to (or as a consequence of):								
09,	ate be ohysicia the bur	edical		d									
Box 6876	requires that the death certificate I been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 🔲 Fetal at time of d	death 3	Ectopic pregnan Other (specify)	cy		23d.	Date of deligible Month	very Day Year	
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al Re	ician: The la certificate ha rector, page	Be Co	25. Was case referred to medical	1			26. F	Place of Death (1 🗌 Yes Check only one)	2 No	1 ∐ Yes	2 L No	
Vita	Physician: this certific al director,	<u>ا</u>	examiner? 1 Yes 2 No				nt 3 LI DOA		ng Home 5 Res			fy)	
on of	nding Plath. r: After ti	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	ation		28b. Time o injury	Wol		28d. Describe	how injury oc	curred		
Division	i ji ift o		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 28e. Place of in building, e	tc. (Specify)		eet, factory, office		City or To	n (Street and Number or Rural Route Number, Town, State)			
	e Hospital 1 24 hours a e Funeral I	Medical	(Chack 2 Medical Ex	Physician: To the best of aminer: On the basis of Nurse Practioner: To the	examination	and/or inves	tigation, in my opin	ion, death occur	rred at the time, date	and place, and	d due to the c	ause(s) and manner stated.	
	To the within 2 To the comple	_	29b. Signature and title of certifier	l-Bas	_ (1	RAP	29c, Licen:	se number 58/40		29d. Date si	gned (Month) $23/2$, Day, Year)	
1			30. Name and address of person w	no completed cause of	death (Item	23a) (Type,			1 Suite o	3041	PRKU,	1k, MD	
	Sta Registr		31. Date filed (Months Says Year)	2014 32. 0015	rar's Signat	ure	- 11					,	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 () Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 213PM Physician/ Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner NIA Itimore Year If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 48-32-8042 Director 1 X M 2 🗆 F 10/27/1941 70 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ ... any injury or other traumatic event. 10d. Inside City Limits 10b. County 10c. City, Town or Location Funeral Director 1 X Yes 2 No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Potomac USA 21205 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc 1 Never Married 2 Married þ Yes 2 No 1 Yes 2 No Specify Specify: Black If Yes, Give Year or Dates. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Un Kwn 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) river Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mallara City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Baltimore, Glenda F. Bandera 1330 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 12/2011 Lansdown, Mr 4 ☐ Donation 5 ☐ Other (Specify) March FIH East 1101 E. North Ave. 21. Signature of Juneral Service 100 Mylan non 21202 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Vear 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy page 2 1 Yes 2 🗆 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

person who completed cause of death (Item 23a) (Typy

32. Registrar's Sign

Print)

Registrar

State

83

gistrar's Signature

Eisenstadt

2011

32.

31. Dete filed (Month, Day, War)

DEC 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 27 Physician/ 7:04 A M Nov. Janos Nemeth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Gilchrist Hospice Care Towson Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 080-32-7814 **Director** 1**XX**M 2 □ F May 18, 1935 76 Hungary Usual Residence of Decedent or 28a-f show e notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits Directo 1XX Yes 2 ☐ No N/A Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? be items 23a oner must be Funeral 21214 4501-03 Harford Road Apt. 3B Hungary 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc. th and Mental Hygiene. 27 is marked other than "natural", or i traumatic event, the Medical Examin Yes 2X No Yes, Give 1 X Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: 3 Divorced 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Home Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Nemeth Ferchend Kantor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5007 New Forge Road Perry Hall, Maryland 21128 Butt/Friend Rosemary or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2XXCremation 3 ☐ Removal from State Hilltop Service Corp. 11/29/11 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or compositions that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Maulto disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death for 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Hinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 100 Be 26. Place of Death (Check only one) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence 6 other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident hin 24 hours after deatl the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ti 29d. Date signed (Month, Day, Year, 29c. License number 27 11 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ARATHI 31. Date filed (Month, Day, Year)

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32. Registrass Signat

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oth 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, Year) Director 1 M 2 F outh Carolina items 23a or 28a-f show her must be notified at 10c. City, Town or Location 10a State 10d. Inside City Limits with the Maryland Director 1 ✓ Yes 2 ☐ No timor 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry (Specify only highest grade completed) It of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me ondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, မ 19a. Informant's Name/Relationship (Type, Print) (Sin) 19b. Mailing Address (Street and Number or Rural oute Number, City or Town, State, Zip Code) 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department Important: If any injury or 4 Donation 5 Other (Specify) o Funeral Service License 21. Signatu 133 222 W Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph sician/ ARDIOPUL MINARY Medical Examiner D. Jux Vasury Sequentially list conditions, if any, leading to infinitelate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the burial-trans MIN KYSIN attending physician and Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Unknown been signed by the a should be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Completed 1 Yes 246. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s within 24 hours fler death.

To the Funeral Director, After this certificate has autopsy 2 No Yes 1 Yes To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 17 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 11-30-2011 son who completed cause of death (Item 23a) (Type, Print) ٤ 33rd (r# 200 State Registrar

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1-08910 Dennis Lee Perr	v. Ji	Please Tyl amend #28	pe or Print i	n Black Inc	delible In	k. Ensure	All Cop	ies Are i	_egibl	е.	11 202	1.
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Physicia		1. Decedent's Name (First, Middle,Last)							2. Date of Death		3. Time of Death	_
Medical Exami	ner								ber 26,		1430 hrs	
	ī	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De 103 5th Avenue SE Glen Burnie						ath		c. County of Anne Arus		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year			f Birth (MN		9. Birthplace (State or oreign	
Director		213-02-3909	1 M 2 F	29	Yrs.	Months Days	Hours N	Oct.	21,19		Country Marylan	d
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other tranmantic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 4210 4th Stree 11. Marital Status 1 Never Married 2 M	12. Was De Armed F 1 Yes If Yes, Give Ye or Dates: College (Last) Ty Sr.	cedent Ever in U.S. forces? 2 X No ar de completed) 1-4 or 5+)	If Ye 1 1 16a. Decedent during mc Barbe	Park 10f. Zip Code 21225 Decedent of Hiss s, specify Cuban, Yes 2 X No 's Usual Occupations of working life. T Address (Street th Stree	panic Origin? (Mexican, Pue specify: on (Give kind of DO NOT use n 18.Mother's Nar Dawn A at and Number of	rto Rican, etc.) of work done retired) me (First, Middone Lloyd or Rural Route	USA r No-	Specify: Williams Specify: Wil	American Indian, Black, etc. hite hess/Industry Industry State, Zip Code) Maryland 21	No
Baltimore, Pages I and Partimore, I bearing to Permit Pages I and Department of Heal unity or other training or other tr		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Structure Funeral Service 23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	complications that con each line.	rom State Cr Ho1	crematory or oth y Cross 22. No. 132 Do not enter th	Cemeter ame and Address 8 Sulphu e mode of dying, s	of Facility And In Springsuch as cardian	nbrose ng Road c or respiratory	Funer Arbu	ooklyn ral Ho utus M	aryland 2122	.7 val
souted and transit	Examiner	b. Due to (or as a consequence of): c. Due to (or as a consequence of): c. Due to (or as a consequence of): d. d.										
cords, P.O. Box 68760, law requires that the death certificate be exclude above that the death certificate be excluded by the attending physician. 2 should be detached for use as the burian plieted by Physician/Medic.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Uni	AMENDED 23c. If yes, 1 Live I 4 Pregi	nant at time of dea	ancy 2 Fet	al death 3 [er (Specify)	Ectopic preg	gnancy		3d. Date of de Month	Day Year		
	1 Yes 2 No 3 Probably						Probably 4 Unknown re autopsy findings available to completion of cause of	ble				
	25. Was case referred to medica	1			26.Place	of Death (Chec	1 🗸 Y	erformed? es 2 1		th? Yes 2 No	_	
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should to	Medical Certification: To Be	3 Suicide 6 Could dete 4 Homicide 29a. Certifier 1 Certifying Pl one) 2 Medical Exa	ding stigation d not be miner: On the basis and manner:	of Injury 1, Day, Year) 1-26-11 2e of Injury - At hor found as st of my knowledge of examination an	t home e, death occurr	jury 28c. Injury pm 1 Y t, factory, office but ed at the time, dat on, in my opinion,	y at Work? es 2 X No uilding, etc. te and place, a death occurred	28f. Location or Tow Glen	ibe how injusting the how inju	103 5tl e,Md. nd manner as lace, and due	or Rural Route Number, C 1 Ave. SE s stated. to the cause(s)	ity
	Σ	29b. Signature and title of certific 30. Name and address of pe, on	M. 1	se of death (Item 2	23a)	29c. License O.C.N				Date signed vember 2	(Month, Day, Year) 7, 2011	
0	- 1	Jack Titus MD. Dep	outy Chief Medi	cal Examiner	900 W. B	altimore Stree	et, Baltimoi	re, MD 212	23			

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ LOOSer ber 26 UID Kerd AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 成208 4b. City, Town, or Location of Death 4c. County of Death Examiner Royal W. Mount Baltimonis Baltinors Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **№** M 2 🗆 F Hours Min. Dav. Country) 237 62 9162 **Director** Usual Residence of Decedent 28a-f show 10b. County within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director 1 Nes 2 No timore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S. Armed Forces?
1 ✓ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 0, δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Divorced Year or Dates traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Men. Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 20a. Method of Disposition

1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 4 Donation 5 Other (Specify) 22 Name and Address Facility Rus 3 Signatu f Funeral Service Licensee Funeral Home MD 23a. Part / Entry the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final As towy Physician ORODAYRY years disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** 300000 Myopath cerco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence on the burial-transi Cause (Disease or linjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Day Year within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached to 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Viabates 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 □ Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe DOUDER RO51063 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13/92 21218 Ravon Blud Kalled Mauroa 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh e922 12-20-11 vt and Mental Hygiene Copies Are Legible. For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Nov 25 2011 2110 M Physician/ John Marion Smith Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Holy Cross Hospital Silver Spring Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** (Month, Day, Year) 54-0230 Director 1 X 2 F 78 Jan 19,1933 Arkansas Usual Residence of Decedent 10d, Inside City Limits 28a-f show 10c. City, Town or Location 10a, State 10b. County ms 23a or 28a-f shor must be notified at death with the Maryland Director 1 Yes 2 XNo Kensington MD Montgomery 10g. Citizen of What Country? 10e Street and Number Funeral 20895 U.S.A 3101 Kent Street Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Examiner Armed Forces or by 1 Never Married 2 Married 2 **X** No Yes Yes Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: Specify:Black If Yes, Give "natural" Completed 3 Widowed 4 Divorced Year or Dates er than "natur the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) t of Health and Mental Hygiene. If item 27 is marked other tha or other traumatic event, the I Education Education Specialist 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) India D. Elston မ Marion B. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3101 Kent St., Kensington, Md 20895 19a. Informant's Name/Relationship (Type, Print) (spouse) Smith Amy L. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 11-28-1 1 Beltsville, Md. Department of Important: If i any injury or conce. 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory Other (Specify) 4 Donation 5 22. Name and Address of Facility Eternal Faith Funeral Syc 5625 Allentown Rd., Camp Springs, Md. 2074 21. Signature of Fu M01576 Napper te*y*én 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Anoxic Brain Injury Phu i ian/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 4 Pregnant
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed the should be det <u>수</u> Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe cate has I death? 1 Yes 2 No 1 🗆 Yes 2 🗀 📉 certificate 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Hospital 1 ☐ Xpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending Accident
Suicide Investigation completely filled in by the 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D66249 Nov. 27. 2011 30. Nameland address of person who completed cause of death (Item 23a) (Type, Print) Forest Glen Rd, Silver Spring, Md. 1500 Jonathan Duran

DHMH 17 Rev 06-2011

State Registrar DEC 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38252 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Melvin Edward Schisler 30 2011 1:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6524 Woodbridge Circle Baltimore Catonsville If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 10-26-1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral 1**X M 2 □ F Hours Min. Director 214-12-4668 Yrs 94 Maryland Usual Residence of Decedent 28a-f show 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes X No Maryland Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö items 23a or ner must be n Funeral 6524 Woodbridge Circle 21228 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【▼No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Medical Examiner Black, White, etc. ŏ ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", 3

▼ Widowed 4 □ Divorced Specify: WHITE Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Al Hygiene. d other than " event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Manufacturing 6 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I မှ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic Daisy Mae Bush John Henry Schigler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aleta Tyree - DAUGHTER 172 Oak Drive, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Crematory INC 11-30-2011 Baltimore Maryland 22. Name and Address of Facility Cremation Society Of Maryland INC f Funeral Service Licensee 299 Frederick Road, Baltimore, MD 21228 Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death MyocardiA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to lor se a consuluence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin at ending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the and be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law in 24 hours after death.
 Funeral Director: After this certificate has b autopsy performed? Yes 2 No page 2 Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) er of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionery to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature a 29d. Date signed / Month. Dav. Year. 30. Name and adoress 705 Digital Drive Suite G, Linthicum MD 21090

State Registrar 31. Date filed (Month, Day,

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 23 655 AM EDITH SHIMEL 2011 11 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Hospital Rosedal Baltimore Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. 1276471935 213 32 7542 75 **Director** 1 M 2 XF Yrs PENNSYLVANIA "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director MD BALTIMORE MIDDLE RIVER 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 16 TOROUE WAY 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 XNo Specify. 3 XWidowed 4 ☐ Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) REC than Elementary/Secondary (0-12) College (1-4 or 5+) MIDDLE RIVER PARKS BUILDING ATTENDANT should be filed with and Mental Hygien 7 is marked other tl Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ **EDWARD** REHRIG EDITH POLTROCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st
Department of Health ar
Important: If item 27 is,
any injury or any WENDI BUTCHER/ DAUGHTER 1823 REDWOOD AVE PARKVILLE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State GARDENS OF FAITH 11/28/11 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Diffuse bowel ischemia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner aortic aneurysm Abdominal Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami vascular dis ease peripheral burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last g physician as the burial Physician/Medical Box 68760 use 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ō Day Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown 9 Unknown P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertension Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 Yes Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural
2 Accident
3 Suicide 5 Pending ours after death.

leral Director: Al

filled in by the ft 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hou To the Funer completely fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES0000 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN Square DR Samuel Hui 9000 DR Balto ind21237 Date filed (Month, 32. Regist ar's Signature DEC 0 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 38254 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Smith Month 11:25 AM 201 Medical Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland) niversity Medica Baltimore Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral **Director** 1**X** M 2 □ F 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Yes 2 No timore ō and Number 10g. Citizen of What Country? Funeral 23a items ? permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. 21215-0036 3 Widowed 4 □ Divorced 1 Yes 2 No Specify. Completed er than "natur , the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 27 is marked other traumatic event, th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Ty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other page 200). Burial 2 Cremation 3 Removal from State 4 Donau...
21. Signature of Funeral Service. Donation 5 Dother (Specify) Part 1. Enter the disease shock, or heart failure Li , or complications that caused the death. Do not enter the mode of st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) a consequence of): **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transi and resulting in death) Last attending physician envie events due to venous occlusion Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ď Pregnant at time of death be detached the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown been signated by the state of t 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autonsy perform after death.

Director: After this certificate 2 No 1 Yes Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🚾 Natural iniury work? 1 🔲 Yes 2 🗌 No filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State, within 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 27/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mont) State Registrar

11-08929 Alvin Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 38255 2011 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 27, 2011 **Medical Examiner** 1120 hrs Alvin Smith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore Washington Medical Center** Glen Burnie Anne Arundel 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs, 8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 219-50-1917 1 X M 2 F Country) 64 Yrs 06/25/1947 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 2 X No Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked ofter than "natural", or items 23a or 28a-f sho ar other traumatic eveot, the Medical Examiner must be notified at now Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7788 East Shore Road 듑 21122 USA Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No White 4 X Divorced If Yes, Give Year 3 Widowed 1 Yes 2 No specify: Specify: É 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 6 Unknown Unknown 17. Father's Name (First, Middle, Last) 13.Mother's Name (First, Middle, Maidon Surname) Alexander Smith Alice Gordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7788 East Shore Road, Alice Amy Morgan (sister) Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place) Dec. 01 1 Burial 2 X Cremation 3 Removal from State Department o Metro Crematory Inc 2011 Baltimore, Maryland 4 Donation 5 Other Specify 21. Signature of Funeral Service/License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD Approximate Interval Part I. Enter the disease, or comul ∜io√s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on and line (Martica) Death *Ouetiapine Intoxication Immediate Cause (Final disease £xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed the attending physician and ed for use as the burial - tran Physician/Medical AMENDED 23a, 27, 28a-f, per me, g922 12-8-11 sm **X** UNPENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown Completed this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes After 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 X No unknown I Director: fd 11-27-11 fd 10:30 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 7788 East Shore Rd.
Pasadena, Md. 6 X Could not be 3 Suicide residence (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 28, 2011 1 Octor 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD State 31. Date filed (Month, Day, Year) 32. Registrads Signature

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38256 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year MOVER BER Day Staffo 1904. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good SAMARITAM Hos BAHIMOR RaHIMUNE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min. Austria 1 M 2 W Director 567-58-9275 Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1117 Ryegate Road United States 21286 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White "natural", Completed 3 X Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) <u>12 years</u> <u>President Jimmys Cab Company</u> <u>Transportation</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Not Known Hilda Helga Schoepke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau H. Richard Sandaal (Friend) 1115 Ryegate Road Towson, Maryland 21286 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp | 12-01-2011 Towson, Maryland 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Road Towson, Ma Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MYOCA 201AL INTARCTION KUTE disease or condition resulting in death) Medical Due to (or as a consequence Examiner ATHEROSCLEPOTIC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi): sician and burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death 5 Other (specify) been signed by the s should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an r this certificate has ral director, page 2 autopsy performed within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital ည 1 Tes 1 Inpatient 2 CEN/Outpatient 3 IDOA 27. Manner of eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural iniury 5 Pending 2 🗌 No Accident 🔲 Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 10.EMBER 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LACH RAVEN BLVD 5601 JUSEPH BALTIMORE MD 21239 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 0 1 2011 Registrar

OHMH 17 Sei 7/2009

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			State	State of Ma	aryland / Dep	artment of F <i>rtificate of L</i>		Mental Hy		2011	0005
			Registrar 1. Decedent's Name (First, Middle, Last)		06.	tineate of E		2. Date of De		2011	3. Time of Death
Section 2	Physicia Medio		Rose Anne Santasar		ieman			Novemb			9:30 P M
The second	Examir	ier	4a. Facility Name (if not institution, give stre 2143 Mardic Drive	eet and number)		4b. City, Town, or Forest		h		ounty of Death rford	
	Funeral Director		5. Social Security Number 6. Sex 18-44-2170 1	"	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	ay, Year)	Cour	
			Usual Residence of Decedent	M 2 X]F	66 Yrs.			11/6/	1945 ———		sylvania
	arylanc a-f sho ified at	ector	10a. State 10b. County Maryland Harford		10c. City, Town or Lo						10d. Inside City Limits 1 Yes 2 No
	a or 28 be not	Funeral Director	10e. Street and Number		TOLEST III	10f. Zip Code				en of What Cou	ntry?
	ath with	uner	2143 Mardic Drive	. Was Decedent E	ver in U.S. 13.	21050 Was Decedent of H	ispanic Origin? (S	pecify Yes or No-		S.A.	can Indian.
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 X Married	Armed Forces? 1 Yes 2 X	No.	If Yes, specify Cuba 1 Yes 2 No	ın, Mexican, Puer	to Rican, etc.)		Black, White,	etc.
21215-0036	hours a natural ical Ex	Completed	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates.	16a, Dece	dent's Usual Occup	ation			d of Business/Ir	
1215	hin 72 ne. than "r ne Med	omo	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	+) life. D	kind of work done of NOT use retired)	during most of wo	rking	Num	sing	
	filed wil al Hygie d other event, th	Be	17. Father's Name (First, Middle, Last)	4	Re	g. Nurse		me (First, Middle			
Maryland	should be file n and Mental h is marked o raumatic eve	인	James Anthony San				Agnes I				
	and 2 sho Health and tem 27 is r	177	19a. Informant's Name/Relationship (Type, Gordon T. Smitheman		_	ng Address (Street a					
Baltimore,	je 1 and t of Hea If item or othe		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Re	moval from State	20b. Place of Dispo		ce)	Date	20c. Loca	ation - City or T	own, State
ltim	permit. Page Department. Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Emeral Service Licenses		Hilltop_	Serv. Cor		2/2011		on, Mar noral H	
Ba	permi Depar Impor any ir		Mula	ann	er 1	.050 York	Road To	owson, M	laryla	nd 2120	ome, Inc. 4
B			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of Immediate Cause (Final	cause on each line	1	^		c or respiratory a	rrest,		Approximate Interval Between Onset and Death
C	Physician/ Medical		disease or condition resulting in death)		reatic consequence of):	Canc	er				
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		I— I	resulting in death) Last	Due to (or as a	consequence of):						
68760	ficate b g physi as the l	N edic	d.						-		
Box 68	ath certificate be ex attending physician for use as the buria	by Physician/Medica	in the past 12 months?	i. If yes, outcome of 1 Live Birth 4 Pregnant at	2 Fetal death 3	Ectopic pregnand Other (specify)	су		23	3d. Date of deliving Month	very Day Year
). Bo	the dea by the a ached	hysic	1 Yes 2 No 9 Unknown	g Unknown	. time of death 5 t	Other (specify)					
, P.O.	res that the death signed by the atte d be detached for	l by P	Part II. Other significant conditions contr	ibuting to death b	ut not resulting in the	underlying cause gi	ven in Part I.				the cause of death?
Records,	v require been si should	Completed						24a. Was	s an	24b. Were auto	ppsy findings available
Rec	sician: The law r certificate has b lirector, page 2 s	Comp						perf	opsy formed? 2 No	death?	ompletion of cause of
Vital	sician: certific lirector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	ent 2 🗌 ER/Outpatie	Oth	ace of Death (Che	eck only one) Home 5 Res	idonas E [Othor /Specif	
of V	ng Phys ter this ineral di	ite: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injui	y 28b. Time o		y at	28d. Describe			у)
Division of	I or Attendin after death. Director: Aft d in by the fur	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, farm, st		Yes 2 ☐ No	28f. Location	(Street and I	Number or Rura	d Route Number,
Divi	ital or / irs after al Dire		4 Homicide determined	building, etc	. (Specify)			1	wn, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b.	Medical	29a. Certifier 1 Certifying Physici (Check 2 Medical Examine) only one) 3 Certifying Nurse F	: On the basis of ex	camination and/or inves	stigation, in my opinie	on, death occurred	at the time, date	and place, a	nd due to the ca	ause(s) and manner stated
	To the within To the comple	2	29b. Signature and title of certifier			T					Day, Year)
			30. Name and address of person who com	poleted cause of de	eath (Item 23a) (Type	Print)	145		11/6	29/20!	1
0			KARL SPECTOR	mo	2014 Tol	Igate Rd	BelA	Ir, mi)	2101	5	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 1 2011	32. Registra	r's Signature	Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38258 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201°1 Physician/ 9:07 November 26. Duane Anthony Sewell Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 6603 Ashdale Road Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Hours 192-60-6053 **Director** 1 🏝 M 2 🗆 F 11/3/1967 Wisconsin 44 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Baltimore N/A 1 🔀 Yes 2 🗆 No Maryland 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 21209 6603 Ashdale Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12 Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Medicine Physician 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fay Allen Trevor E. Sewell 19a. Informant's Name/Relationship (Type, Print) and is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Catherine A. Sewell / Wife 6603 Ashdale Road Baltimore, Maryland 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 a 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>+</u> ō Department of Important: If any injury or Hilltop Serv. Corp. 11/30/2011 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signature of Funeral Sen 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 stric disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical death certificate be P.O. Box 68760 as the b IF FEMALE ase a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attanding Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: autopsv perforn 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred Certificate: iniurv Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one DIRECTOR, 29c. License number 29d. Date signed (Month, Day, Year) 2367 11.29.11 aum MEDICAL ONCOLOGY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PISS C. DONEHOWED, ND JOHN'S HIPPUTUS CHIEF IOV Beltrusue 21287 Center POSS C DONEHOWER, MD

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		T = State Registrar				06	ertificate of	Dealii			Reg. No.			
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hysician: The law requires that the death certificate be executed The law requires that the death certificate be executed It director, page 2 should be detached for use as the burial-transit But and a detached for use as the burial-transit But a detached for use as the burial-transit for use as the burial-t	Certificate: To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter to shock, or heal Immediate Cause (disease or condition resulting in death) Sequentially list colif any leading to in cause. Enter Under Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was decedent in the past 12 1	nditions, interest of the conditions of the cond	Due to come of preg Birth 2 F nant at time on nown leath but not in the pregion of injury - At ng, etc. (Speciest of my king; so of my king; so of my king; so of examinar; To the best of the present of the p	equence of): a uence of: equence of): equ	Desirable and a contract of the mode of dying and a contract of the mode of dying and a contract of the contra	Place of Deher: 4 I I I I I I I I I I	rt I. Path (Check Nursing Ho No Accurred at date and pla	23e. Did 1 24a. Wa: aute per 1 Per 28d. Describe 28f. Location City or To	tobacco us Yes 2 Yes 2 tobacco us Yes 2 Another to the cause (s) thow injury cause (s) and and place, the cause (s) the cause (s) 29d. Date W.A.	Month se contribute t No 3 F 24b. Were an prior to death? 1 Ye other (Spe occurred Number or Ru d manner as s and due to the s) and manner es signed (Monta)	elivery Day Year o the cause of death? Probably 4 Unknow utopsy findings availate completion of cause es 2 No crify HOSPI ural Route Number, stated. e cause(s) and manner sas stated.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 38260 For State Registrar Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ NANCY SUE STCLAIR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Hagerstown Washington If Under Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 □ M 2 □X Months Hours Min **Director** 174-50-3313 1955 Pennsylvania Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Washington 1

✓ Yes 2 □ No Hagerstown 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be I Funeral 1306 Jay Drive 21740 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. White Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 4+ Licensed Practical Nurse permit. Page 1 and 2 should be filed wit Department of Heath and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, th Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 M. William Ryder Shirley Rock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Lee St. Clair (Husband) 1306 Jay Drive, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation 12/1/2011 Hanover, MD eral Service Licen 22. Name and Address of Facility Latimore Funeral Services, PA alrece alin 2818 E. Baltimore Street, Baltimore MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACUTE RESPIRATORY Onset and Death FAILURE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PSIS St Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last ATRIAL attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) Physician/Medical MORBID P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the sid be detached f 9 Hospital or Attending Physician: The law requires that the 124 hours after death.
Parneral Director: After this certificate has been signed by the leted filled in by the funeral director, page 2 should be detacht. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Tes 2 1 No ည 1, Dinpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 \square Pending work? 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1212 MOHAMMED 11/28/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11116 Medical Campus Rd. Hage stown, MO 21742 Morammed MO 31. Date filed (Month, Day, Year Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38261 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 Month Physician/ **22** Day 2011 Angela Olivia Smith 6:59p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Ritchie Hospice N/A Baltimore Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 M 2 X 0677271949 Maryland 216-52-1913 62 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1226 Druid Hill Ave. 21217 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 3 2 **N**O Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify: Completed 3 Wildowed 4 Divorced Black Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 73 f Health and Mental Hygiene. item 27 is marked other than 12th Grade College (1-4 or 5+) Word Processor self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Ellis Marion White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monyette Smith(daughter) 1226 Druid Hill Ave., Baltimore, MD21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Peremation 3 Removal from State on-site crematory | | 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. 2140 N. Fulton Ave., Jr. Funeral Home PA amo Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pred 23d Date of delivery in the past 12 mg Pregnant at time of death Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con ute to the cause of death? Completed by Division of Vital Records, 200 cate has been sig page 2 should b 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 2 🗆 No Yes 25. Was case referred to Be 26. Place of Death (Check only one) Hospital 2 **N**o ᅆ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred **Hospital or Attending** Natural 5 Pending injury 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide mined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer 29c. License number State

Registrar

Mela Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38262 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Charlie D. Smyre November 1815 PM Medical 2011 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A **Examiner** 4b. City, Town, or Location of Death Maryland General Baltimor If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign nonth, Day, Yo Days 1 **X** M 2 □ F Months Hours Min. Director 229-48-9697 Virginia 69 Usual Residence of Decedent items 23a or 28a-f shov ler must be notified at 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No N/A Baltimore City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1027 Cathedral Street, Apt.4G 21201 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White etc. than "natural", or 1X Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Year or Dates Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Grade BGE Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charlie R. Smyre Jennie Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) per it. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr. onc e. (sister) 1610 N. Monroe St, Baltimore, MD 21217 Ella Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cem. 12/2/2011 Lansdowne, 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave, Baltimore, M PA 21217 ΜĎ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Cancer (Small cell) with metastasis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine for as a consequence Rena Acute -allur sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy e Hospital or Attending Physician: The I 24 hours after death. • Funeral Director: After this certificate h leted filled in by the funeral director, page performed Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛂 No Other: ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 23, 201 Name and address of person who completed cause of death (Item 23a) (Type, Print) hana 31. Date filed (Month, Day State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0507 M NOV 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis Date of Birth (Month, Day, Yes If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Year) 1 M 2 □ F Hours 225-36-9051 Sept. 1925 Virginia 86 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, train of the Evantian of the training of 1 ☐ Yes 2 X No Directo Maryland Anne Arundel Odenton 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 1212 Odenton Road Apt.#214 21113 United States Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. om 27 is marked other than "natural", or ite 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify 2 Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) llgrade Press Operator Kaiser Aluminum 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Tolley Alice Coyner ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra 1212 Odenton Road Apt. #214, Odenton, Maryland 21113 <u>Gertrude Tolley/ Wife</u> 20b. Place of Disposition (Name of CROWNSX Cramatory grouper place)
CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State Dec.2,2011 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence to: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed Exami INSON and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year signed by the a d be detached for 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed' 1 ☐Yes 2. ZNo 1 ☐ Yes 2 ☐ No Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

Name and address of person

DEFENSETHWY ANNAPOLG 32. Registrar's Signature

tho completed cause of death (Item 23a) (Type, Print)

MO

445

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ CAROCYN 8:19 **9** M ,2011 JAN DUKE NOUEHBER Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SIURUB UBJIS ANN ARWINDER BALTIMORE-WASHINGTON MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** 1 □ M 2 🎖 F Months Days Hours Min NOV. 16 ^{Year)}925 Country) Yrs. **Director** 220-18-6636 86 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City. Town or Location Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 Funeral 19 Brookfield Road 21122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 X Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harold L. Hughes Schellhas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brookfield Road, Pasadena, William E. Van Dyke (husband) MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 2011 Glen Burnie, Maryland Glen Haven Cemetery of Furieral Service 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between mmediate Cause (Final Onset and Death Ph_sician/ OBSTRUCTIVE FULMONARY DIERSE EXECERMINA CHROPIC 24405 disease or condition Medical resulting in death) **Examiner** 204EARS CHROME OBSTRUCTIVE PULHOUARY MICESE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician use as the burial Physician/Medical P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Li Fetal Geath Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 🔀 No ō Month Day Year the g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy has certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ ER/Outpatient 3 DOA 1 X Inpatient 2 this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completed filled in by the funeral completed filled 1 Natural 5 \square Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

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CUILLERMO JOSE GIANERECO

1 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D00 C 5 ± 1 A

301 HOSPITAL DRIVE, GLEH BURHIE, MD 20161

29d. Date signed (Month. Day, Year)

HOVEKBEK 3A 350 //

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Carolyn Davidson Von-Schnell 11-08859 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 2011 1- For State Certificate of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 24, 2011 ical Examiner Carolyn Davidson von Schnell 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Baltimore County** 1339 Phoenix Road 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Months Davs Hours Min. Director Country) Maryland 2 X F 1960 212**-**72**-**8072 51 July 31 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 1 Yes 2 No I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene.
item 27 is marked other than "natural", or items 23s nr 32s - 5 hours MD Baltimore Sparks Directo 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country **USA** 1343 Phoenix Road 21152 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White etc Armed Forces? 1 Never Married 2 Married 2 X No Yes If Yes, Give Year Specify: White 3 X Widowed 4 Divorced 1 Yes 2 No specify: 2 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Pharmaceutical Researcher 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Nancy Collier Be H. C. Davidson Fait 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy C. Fait 1102 Hampton Garth; Towson, MD 21286 mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Cremation 3 Removal from State permit. Pages 1
Department of H
Important: If i 1 Burial 12/1/2011 4 Donation 5 Towson, MD Hilltop Service Corp. Other Specify 21. Signature of F 22. Name and Address of Facility 1050 York Road Towson, MD 21204 kuck Towson Funeral Home, Inc. Approximate Interval failure. List only one cause on each line is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and /Medical Death Thermal Injuries and smoke inhalation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical g922 12-6-11 sm XX_{AMENDED} 23a, 27, 28a-f, per me #2 Per ME G923 1/30/2012 X UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed^a ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene this 1 🗸 Yes ۵ 28d. Describe how injury occurred driver in auto/fixed object collision and vehicle fire After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 Natural 1 Yes 2 🗶 No Pending within 24 hours after death. tþ fd 11-24-11 fd 11:15 am 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State)1339 Phoenix Rd. determined (Specify) road To the Funeral Homicide Sparks,Md. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) November 25, 2011 O.C.M.E.

2 of prof

31. Date filed (Month, Day, Year) 32. Regi

Donna M. Vincenti, MD

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Nonth 47 PM ARCANI Medical la. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, g. Birthplace (State or Foreign **Funeral** Months Min 1 M 2 🗆 F Director 0 28a-f show 10c. City, Town or Location death with the Maryland at 10b. County hside City Limits Director notified 1 Yes 2 No More ritems 23a or ner must be n ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian, the Medical Examiner __iZ15-0036
__snould be filed within 72 hours after de.
Health and Mental Hygiene.
ym 27 is marked other than "er traumatic event" Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) ည veni permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) MD Baltimore, Method of De 1 Burial 2 position 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date crematory or other pi 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Memorial 10 f Funeral Service Licensee Sign Home, P. MD 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No be detached Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 2 No 3 Probably 4 Unknown Completed should . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s After this certificate has autopsy perform death? 2 No Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ျ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of injury Mann Death Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural 1 🗌 Yes 2 🗌 No Accident Investigation Could not be within 24 hours after deat To the Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely (Check 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title me and address of person who comple ted cause of death (Item 23a) (Type, Print) BOB 31. Date filed (Month, Day, Year) State

Registrar

1-08781 Raymond Wright		nt in Black Indelible I aryland / Department o <i>Certificate</i> o	f Health and Mental H	ygiene 2	011 382
Physician Medical Examine	Raymond	Wright		Reg. No. 2. Date of Death Month Day Yea November 22, 2011	0/53 hrs
	4a. Facility Name (if not institution, give street Good Samaritan Hospital	and number)	4b. City, Town, or Location of Death Baltimore	4c. County c	of Death NA
Funeral Director	5. Social Security Number 6. Sex 219-66-6152 1 M 2	7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY 06-02-57	9. Birthplace (State or Foreign Country) MD
hours after death with the Maryland natural", or items 23a or 28a-f show any Examicer must be notified at once.		as Decedent Ever in U.S. med Forces? Yes 2 No	re 10f. Zip Code 21218 as Decedent of Hispanic Origin? (Spres, specify Cuban, Mexican, Puerto	10g. Citizen of Wh US secify Yes or No- Rican, etc.)	
after	15. Decedent's Education (Specify only higher Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	ive Year 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		vork done red) 16b. Kind of Busted) Unite (First, Middle, Maiden Surname)	d Van Lines
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Iten 27 in marked other than "natur injury or other traumatic evect, the Medical Exam	Sammie 19a. Informant's Name/Relationship (Type, Prir Edith Wright-Moth 20a. Method of Disposition 1	oval from State 110 20b. Place of Dispo crematory or or King Mer	Edith g Address (Street and Number or F N. Central Av sition (Name of cemetery, ther place) n. Pk. 12- Name and Address of Facility Wy 38 N. Gilmor S	enue Apt.#32° Date 20c. Location- 01-11 Randa Tie Funeral	9 Baltimore City or Town, State 11stown, MD Home P.A.
Physician Action Examiner	or condition resulting in death) Due to (conditions)	() 0			
execut an and al - tra	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9	Pregnant at time of death 5 0	etal death 3 Ectopic pregna	23d. Date of o	Day Year
Records, P.O. B The law requires that the d ficate has been signed by the page 2 should be detached	Hunantanaire Haant			24a. Was an 24b. Was autopsy performed?	Probably 4 Unknown Vere autopsy findings available rior to completion of cause of eath?
Division of Vital ospital or Atteoding Physiciaes bounds after death, oceral Director: After this certi y filled in by the funeral director	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Sp. 29a Certifier.	Date of Injury (Month, Day, Year) 28b. Time of (Month, Day, Year)	Injury 28c. Injury at Work? 1 Yes 2 No et, factory, office building, etc.	only one) g Home 5 Residence 6 28d. Describe how injury occurre 28f. Location (Street and Numbe or Town, State)	r or Rural Route Number, City
To the H within 24 To the R To the R Complete	30. Name an address of person who complete		29c. License number O.C.M.E.	29d. Date signe November 2	d (Month, Day, Year)
State Registra	31. Date filed (Month Day Year)	ssistant Medical Examiner 32. Degrarar's Signature	500 vv. baitimore Street, B	ammore, MD 21223	

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38268 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Notether 201 Year Physician/ 3:40 P M Rosemary Wessel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Oakcrest Care Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours Min. Mayonth 7 ay, 1919 92 Mencylend 219-01-0679 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore Parkville 1 Yes 2X No Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral U.S.A. 21234 8800 Walther Blvd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-003 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Johns Hopkins Hospital Purchasing Manager , Roseman To Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theresa Kleiderlein Frederick Finke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11933 Hartley Mill Rd. Glen Arm, Maryland 21057 Mary Davis / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Gardens of Faith 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 12/3/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ pneumonics disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) the s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No dementic 24a. Was an end stage has autopsy performed page 2 aibrillat certificate 25. Was case referred to medical filled in by the funeral director. 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 058646 29, 2011 Wovembes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boulevord Parkville, MD 6800 walther

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 1 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month | Physician/ Day 28 WHALEN, SE :15 P. M THOMAS Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE, MARYLAND ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min 220-38-7181 71 **Director** Usual Residence of Decedent 28a-f shov 10b County 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Pasadena 1 🗆 Yes 💥 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 185 Chelsea Road 21122 USA 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? ↓ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc ģ 1 Never Married XX Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify Specify: White 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fire Fighter Baltimore City Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Webster Whalen Goldie Alberta Clem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Virginia D Whalen / Wife 185 Chelsea Road Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 12/2/2011 Crownsville, MD 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Fart 1. Enter the disease or shock, or heart failure. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ REFRACTORY ACUTE MYELOGENOUS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by -HYPERTENSION Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes - HYPERLIPIDEMIA 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of death? - CORONARY ARTERY DISEASE Yes 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be

P.O. Records, Hospital or Attending Physician: The law requires Division of Vital

WHALEN

Medical

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Reddy

DEC 0 1 2011

determined

4 Homicide

only one)

29a. Certifier (Check

301 Hospital Drive 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Glen Burnie, MD 21061

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D69090

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f, Location (Street and Number or Rural Route Number

28

29d. Date signed (Month, Day, Year)

2011

City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 3827 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 Month Physician/ 26 2011 4:45 PM JAMES JOHN WOOMER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12394 Ridge Road Lusby Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days 1 🔀 M 2 🗆 F 04 18 1924 Months Hours Min. Country) 87 Director 216 16 2473 MD Usual Residence of Decedent Strong to more in the strong of the strong o 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Tes 2 No Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20657 12394 Ridge Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 💆 Yes 2 🗆 No 1942 -Black White etc. 2 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced 1946 White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) Gas and Electric 4 Supervisor Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jerome John Woomer, Sr. Clara Virginia Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 12394 Ridge Rd James Woomer - Son Lusby, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem Pk 12/1/201**1** Elkridge, 22. Name and Address of Facility GJ Gonce Funeral Home 21. Signature of Funeral Service Licensee e, PA 21122 169 Riviera Pasadena, MD Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Year 1 Yes 2 No detached g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be c al or Attending Physician: The law requires to after death.

Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 6 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 6+1 30. Name and address death (Item 23a) (Type, Print) all 31. Date filed (Month) State

DHMH 17 Rev 7/2009

Registrar

Box 68760

Records,

Division of Vital

		For State	State of Marylan				Mental Hyg	~ .	111	2027
-	_	Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	Death	2. Date of Deat	og. Ito.		3821
Physic			41					r 25, 2	ďe ^{ar} 1	3. Time of Death 1:00 P M
Med Exami		Lillian O. Who 4a. Facility Name (if not institution, give stre	eatley eet and number)		4b. City, Town, or	Location of Dea		4c. County of		1.00 1
	*	5749 1st Ave.			Haletho	rpe		Baltin	nore	
Funera		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			9. Birthpl Countr	lace (State or Foreign
Directo	r	218-22-2572 Usual Residence of Decedent	M 2 🔀 F 84	Yrs.			May 26,		Kentu	
ind show at	ľ	10a. State 10b. County	10c. City	, Town or Loc	ation				10	Od. Inside City Limits
Aaryla 8a-f s tified	Director	Maryland Baltimore	Hale	thorpe						1 🗌 Yes 2 🔀 No
the A	Ö	10e. Street and Number	, , , ,	on or p	10f. Zip Code			0g. Citizen of W	hat Count	ry?
n with	Funeral	5749 1st Ave.			21227		Uı	nited St	ates	
ours after deat tural", or iten al Examiner r	ğ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in U.S Armed Forces? ☐ Yes 2 XNo If Yes, Give Year or Dates. 	l II	Vas Decedent of Hi Yes, specify Cuba Yes 2XXNo	n, Mexican, Pue			- America k, White, e Whit	tc.
in 72 ho e. nan "na	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give I	ent's Usual Occupa ind of work done of NOT use retired) aker		orking	16b. Kind of Bu		ustry
yidiid z I	To Be C	17. Father's Name (First, Middle, Last) Homer Fannin				18. Mother's N E li z	ame (First, Middle, A cabeth All	Maiden Surname) .en		
d 2 should alth and Marth		19a. Informant's Name/Relationship (Type, Stephen Cooper-Sor					Oural Route Number,			ode)
of Hez		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re		lace of Dispo emetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location -	City or Tov	vn, State
Dallillor Dermit. Page 1 Department of mportant: If is any injury or conce.		4 Donation 5 Other (Specify)	Gle				30,2011			
Dermit Depart Impor any in		21. Signature of Funeral Service Licensee	Cato	13	28 Sulphi	ur Spr i n	nbrose Fur ng Road Ai	butus M		
Physician	_	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death cause on each line.		the mode of dying		ac or respiratory arre	st,		Approximate Interval Between Onset and Death
Medica Examine	_	resulting in death)	Due to (or as a consequ	ience of):	No.					
ed sit	miner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequ	ence of):						
rate be executed physician and the burial-transit	dical Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):						
ate be hysici		d.								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of c	ldeath 3	Ectopic pregnand Other (specify)	y		23d. Date Mor	e of delive	ry Day Year
gned by i	by Phy	Part II. Other significant conditions control		ulting in the u	nderlying cause giv	ven in Part I.				e cause of death?
equire	eted	O TO CONTINUE	<i></i>		<u> </u>		1			ably 4 Unknown
The law require: cate has been signage 2 should b	Completed by						24a. Was a autops perfori 1 Yes	med? p	rior to con eath?	sy findings available inpletion of cause of
sician: certific	Be	25. Was case referred to medical examiner? 1 Yes 2 Ho	spital:		_ Othe	ace of Death (Ct				
nding Phys th. After this e funeral di	cate: To	27. Manner of Death 1 A Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 I 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury	4 ∐ Nursing ⁄at	28d. Describe ho			
DIVISION OF	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (St City or Town		r or Rural i	Route Number,
ne Hospit n 24 hou ne Funera	Medical	(Check 2 Medical Examine)	an: To the best of my knowler: On the basis of examination Practitioner: To the best of r	and/or invest	igation, in my opinio	on, death occurre	d at the time, date an	d place, and due	to the cau	se(s) and manner stated
To the within common co		29b. Signature and title of certifier Charles Mula-4	/		29c. License	number	2	9d. Date signed	(Month, D	lay, Year)
		0. Name and address of person who com	m. MD. 10	OI Pir	(rint) Heigh	ts Ave	#300 B	Mto M	0 2	4229
St Regist	ate trar	31. Date filed (Month, Day, Year) DEC 0 1 2011	3.f. Registrar's Signat	ture	Mar					

Registrar
DHMH 17 Rev 06-2011

Please Type of Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar 38272 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month РМ Charles William Wood 2:15 Medical 20 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson N/A . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** g. Birthplace (State or Foreign 218-01-4462 Country) **Director** 1 **X** M 2 □ F 95 9/23/1916 VA Usual Residence of Decede 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location must be notified at 10d. Inside City Limits Director N/A Towson 1 X Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3106 E. Federal St. 21213 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 A No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner o by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meonee. Elementary/Secondary (0-12) College (1-4 or 5+) American Standard Laborer N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Wood Svlvia Cosbv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Wood - Sister 5200 Bowleys Lane Apt. 312 Baltimore, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/1/2011 Owings Mills, MD Carrison Forest Cemetery Donation 5 Other (Specify) e of Funeral Service Licenses 22. Name and Address of Facility March F/H East 1101 E. North Ave. Baltimore, MD 21202 Pa / 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipck, or heart failure. List only one cause on each line. Approximate Interval Between me liate Cause (Final Onset and Death Ph_{sician/} ENDSTAGE RENAL DISOASE die se or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) -tran and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE: asn 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Day Month Year signed by the a 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by METASTATIC PROSTATE CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should peen PULMONARY EMBCUSM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has autopsy performed? Yes 2 No filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSA CO 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident

Suicide

Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi-674 North Chrues Street Date filed (Month, Day, State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 940 AM NIDO tor Javen be Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City Town or Location of Death Examiner Balhmore 8. Date of Birth 6hns HOPKINS -ospital N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Security Numbe 9. Birthplace (State or Foreign **Funeral** Days Min (Month, Day, Year) Hours 176-42-1485 Director 1 X M 2 □ F 58 PA 3/18/1953 or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 X Yes 2 \(\subseteq No Baltimore MD N/A 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 21213 IISA 1609 Rutland Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: item 27 is marked other than "natural", other traumatic event, the Medical Exal 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ducant Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Charlie Wise Corrie Clinkscale 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Wise - Wife 1609 Rutland Ave. Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of P
Important: If it
any injury or of 1 X Burial 2 Cremation 3 Removal from State 12/2/2011 Philadelphia, PA Chelton Hills Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Atheroscleration disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of physician and strans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the at Id be detached fo 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Linknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? Yes 2 \(\Delta\) No death? within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending 1 X Natural 1 Yes 2 No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined City or Town, State) Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number . JALKLI MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe St. Bultmore 600 N. 32. Registrar's Signature

Registrar DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death November Yazdanivan 272011 **Physician** rouran /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month Day, Year) April 5 1946 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Min. 1 □ M 2 🛱 F 65 Iran 601-97-3537 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or Items 23a or 28a-f show 1 Yes 2 X No Director Maryland | Baltimore Timonium 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21093 2302 Springlake Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 ¥ Widowed 4 □ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15 Decedent's Education the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roohieh Kashani Hossein Yazdaniyan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 2302 Springlake Drive, Timonium, Maryland Fardad Borhani / Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12/2/2011 Towson, Maryland HilltopServiceCorp. 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service. Leensee 1050 York Road Towson, Maryland 21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis **Physician** Days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Colon Cancer Metastatic months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner nver Failure Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical Renal IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No P.O. Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> Division of Vital Records, Heratic Encephalopathy 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 Tes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☑ No မ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a 1 V certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and time of certifier M.D. Res-000 November 27,2011

DHMH 17 Rev 1/2001

State Registrar DHRUY

31. Date filed (Month, Day, Year)

DEC 0 1 2011

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSHI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011 38275

		1- For State Registrar	Ce	ertificate o	Death		Re	g. No.	0021
Physicia Medical Exami		Decedent's Name (First, Middle,Last)	Frederick D	Evan Zel	lmer II	I	2. Date of Death Month November	Day Year	3. Time of Death 1936 hrs
		Facility Name (if not institution, give stree Robinhood Road	et and number)		4b. City, Town, o Havre de (or Location of Dea Grace	th	4c. County of Harford	Death
Funeral Director		5. Social Security Number 6. Sex 213-08-5630 1 X M	7. Age (In yrs. 27	. last birthday) Yrs	If Under 1 Ye Months Da			h(MM/DD/YYYY) 3, 1984	9. Birthplace (State or Foreign Country) Maryland
w any		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Locat					10d. Inside City Limits
Aaryland 28a-f show 1 at once.	혅	MD Harford 10e. Street and Number	Ha	avrede G	race		[40	g. Citizen of Wha	1 Yes 2XX No
th the Maryland 23a or 28a-f sho notified at once.	I Director	4 Robinhood Road			210	78		USA	at Country?
MD 21215-0036 2 should be filed within 72 bours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fash matte event, the Medical Examiner must be notified at once	Funeral		Was Decedent Ever in the Armed Forces? Yes 2 X No			an, Mexican, Puert	Specify Yes or No- o Rican, etc.)	White,	
ours aft atural"	d by	or Da 15. Decedent's Education (Specify only high	tes:		t's Usual Occup	ation (Give kind of		Specify: 16b. Kind of Bus	White iness/Industry
5-0036 led within 72 bo Hygiene. other than "na the Medical Ex	Completed	Elementary/Secondary (0-12) C	ollege (1-4 or 5+)		ost of working lif	e. DO NOT use re	tired)	Insta	llation
5-003 fled within Hygiene. If other the		17. Father's Name (First, Middle, Last)				18.Mother's Nam	e (First, Middle, M		
2121 ould be fil Mental I marked e event,	To Be	Frederick Evan Zel. 19a. Informant's Name/Relationship (Type, P		19h Mailing	Address (Stre	Rita I	Ensey Rural Route Numl	her City or Town	State Zin Code)
MD 2 d 2 shou lth and l	-	Rita Ensey - Mother	,	100	,		Baltimore		
		20a. Method of Disposition 1 Burial 2 X Cremation 3 Re		Place of Dispos	ition (Name of c		Date		City or Town, State
Baltimore, sermit. Pages I ar Department of Hec Important: If ite Injury or other tr		4 Donation 5 Other Specify:		lantic	Cremato:	ry Nov	7.282011	Glen Bu	rnie Maryland
Baltimo permit, Page Department Important: injury or ott		21. Signature of Funeral Service Licensee	ws				orose Fur		me Inc. Maryland 21227
Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each line							
/Medical			cohol and (or as a consequence		ne Into	<u>xication</u>			Death
	Jē.		(or as a consequence	of):					
d d	Examiner	(Disease or injury that initiated events resulting in death) Last	(or as a consequence	of):					
760, icate be executed physician and the burial - transit	/Medical E	d. 🕱 UNPENDED 🕱 AME	NDED 1,23a,	27,28a-	f per me	g923 1-	-3-12 vt		
		001 144 1 1 1 1 1 1 1 1 1	. If yes, outcome of preg			Ectopic pregn		23d. Date of d	
Box 68's death certiff	Physician	past 12 months? 1 Yes 2 No 9 Unknown	Pregnant at time of de	lo oth	al death 3 ner (Specify)	Ectopic pregn		Month	Day Year
P.C.	<u>a</u>	Part II. Other significant conditions contri	puting to death but not	resulting in the u	nderlying cause	given in Part I.			ute to the cause of death? Probably 4 Unknown
of Vital Records ng Physician: The law requi ther this certificate has been i meral director, page 2 should	Completed						24a. Was ar autops perform	y pri ned? de	ere autopsy findings available or to completion of cause of ath?
I Re		25. Was case referred to medical			26.Plac	e of Death (Check	1 Yes 2	No 1	Yes 2 No
Vita hysicia this cer	o Be	examiner? 1 Yes 2 No	1 Inpatient 2	ER/Outpatient			ng Home 5 R	Residence 6	Other: Scene
ding Ph. After tl	Ë	1 Notural	da. Date of Injury (Month, Day,Year)	28b. Time of Ir		ury at Work?	28d. Describe ho	ow injury occurred	3
Division tall or Attending a first or after death.	catic	2 Accident Pending Investigation	d.11-20-11 Be. Place of Injury - At h	fd. 19:	1/ -	Yes 2 X No	unknown		or Rural Route Number, City
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	Suicide Could not be		sidence	i, ractory, office	building, etc.	or Town, Sta Havre d	e Grace,	oinhood Rd.
To the Ho within 24 I To the Fu completely	Medical	(Check only one) 2 Medical Examiner: On the							
	Ž	29b. Signature and title of certifier	'Oan		29c. Licen	se number .M.E.		29d. Date signed November 2	1 (Month, Day, Year) 1, 2011
	-	30. Name and address of person who completed Carol Allan, MD Assistant Me	ted cause of death (Item		more Street	. Baltimore. M	ID 21223		
Sta Registi		31. Data-filed (Mopth, Pay Year)	32. Registrar's Signat						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, 1-State Registrar #5, TCHD, FH, 11/9/11, rls Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10-31-2011 823 P M Lovena A. Atwell Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Talbot Easton Talbot House Hospice 5. Social Security Number 4 2 Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 6-(Month, Pay4^{Year)} 1 □ M 2 💢 F 67 Director 220-44-1253 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No MD Talbot Easton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21601 6956 Hopkins Neck Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural" 3 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Super Giant 12 Marketer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Lovena Campbell Robert Waite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (husband) Easton MD 21601 Charles E. Atwell, Jr. 6956 Hopkins Neck Rd 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Chesapeake Cremation Center 1 Burial 2 X Cremation 3 Removal from State 11-2-2011 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) of Fulleyal Service Ly 21, Signal Fellows, Helienbein & Newnam Funeral Home, P.A. 200 S. Harrison Street Easton MD 21601 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Opset and Death
2 4 ERC 23a. Part 1. Enter the disease, or complicatio shock, or heart failure. List only one cause Immediate Cause (Final BREAST CANCER Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and ruse as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death g 🗌 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has I performed Vas 2 2 🗌 No After this certificate 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) the funeral director. Other: 4 \(\sum_{\text{Nursing Home}}\) 1 \(\text{Design} \) 1 \(\text{Residence}\) HOSDICE မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred house Certificate: 28c. Injury at Natural 5 Pending 1 Yes 2 No Accident Investigation 124 hours after deat e Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie completed

DHMH 17 Rev 7/2009

State Registrar

within 2 To the 1

(Check

only on

David Smith

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8221 Teal Drive

29b. Signat

Easton MD 21601

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D3988

29d. Date signed (Month, Day, Year)

11-2-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 13, 2011 G. 6:50 A M Michael Andresini. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Somerford Place Columbia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 219-18-3941 **Director** X M 2 D F June 6, 1924 87 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits aţ 10a, State 10c. City, Town or Location Director Examiner must be notified 1 Yes 2 No MD Howard Marriottsville ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21104 12116 Deer Haven Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1944-46 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3x Widowed 4 ☐ Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Roofing Company Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andresini Alfonsina Mancini Pasquale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 2116 Deer Haven Road Marriottsville, MD 21104 Zina Poliszuk/daughter injury or other Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If ite any injury or otl 1 X Burial 2 Cremation 3 Removal from State Lorraine Park Ceme. 11/17/2011 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry II. Witzke's Family F.II. Inc 21. Sign Fure of Funeral Service I 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Vascular Dementia disease or condition 2vrs Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury law requires that the death certificate be executed and I-trans that initiated events Due to (or as a consequence of): resulting in death) Last burial physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Į, in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Diabetes Mellitus has performed? page death? History of Stroke Hospital or Attending Physician: The 2 🔀 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be ASSISTED examiner? Other: 4 Nursing Home 5 Residence 6 M Other (Specify) Hospita 1 🗌 Yes 2 🔀 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer 1 X Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56531 November 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Snowden River Pkwy #301, Columbia, Md. 21045 Harry Li

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 4 2011

A. park

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Michael 201 Joseph Medical acility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Vicomico egional If Under 24 H 9. Birthplace (State or Foreign 8. Date of Birth Age (In vrs. last birthday) **Funeral** Min (Month, Day, Year) **Director** 1 **№** M 2 □ F 3 ما mD4-4-1948 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 Yes 2 No Hcco mack hincoteague o 10e, Street and Numbe 10g. Citizen of What Country? Funeral 23a 6359 or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) are Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Adams Michael Elizabeth Sarah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33336 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Occohannock -7-2011 4 Donation 5 Other (Specify) Crematory Exmore, VH Chincolague 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6327 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final SC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown the g Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Funeral Director: After this certificate has stely filled in by the funeral director, page 2 autopsy performed' 2 🗌 No Yes 2 4 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Yes ER/Outpatient 3 DOA မ 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work?
1 Yes Natural 5 Pending 2 No ☐ Accident Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of contifier D 58 689 3/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRMC 100 E Carroll St. oma M. D . Registrar's Sigr

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death State
Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Monthember Physician/ Jeannette Marie BROWN Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Washington Hagerstown Meritus Medical Center Birthplace (State or Foreign 8. Date of Birth

(Month, Day, Year)

Dec. 4, 1934 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number Min **Funeral** Days Hours Months 1 □ M 2🕱 F Maryland 76 214-32-4789 Director Usual Residence of Decedent 10d. Inside City Limits show 10c. City, Town or Location 10a. State death with the Maryland Director 1 Yes 2 X No ms 23a or 28a-f s must be notified Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 30 South Colonial Drive, Apt. "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2X No
If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after topportment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event: the Maximal Exercises. þ 1 Never Married 2 Married 1 Yes 2 XNo Specify: white Baltimore, Maryland 21215-0036 3 X Widowed 4 Divorced Shows ...
It and Mental Hygiene.
27 is marked other than "natural" Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) her own home homemaker 0 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Anna E. Jones ဂ္ Edward R. Houser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12304 Big Pool Rd., Clear Spring, Maryland 21722 Sally Poole - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State Hagerstown, Maryland 11/16/11 Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) MINNICH FUNERAL HOME 22. Name and Address of Facility Signature of Funeral Service Licen E. Wilson Blvd., Hagerstown, Md. 21740 .5 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Liver Immediate Cause (Final disease or condition ry hos, Physician/ Due to (or as a consequence of): Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy IF FEMALE 23d Date of delivery use 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year ned by the atten edetached for u Pregnant at time of death in the past 12 months?
1 Yes 2 No 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has Yes 26. Place of Death (Check only one) 25. Was case referred to medical director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 🖵 No 1 🗌 Yes ပ္ 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death Certificate: 1 Natural injury 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide
Homicide 24 hours after death. Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Could not be City or Town, State) determined Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 To the l within 2 To the l 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifier 0060 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 MP FARID

State Registrar 31. Date filed (Month

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State of	Maryland / Dep			Mental Hy	giene		
		_	Registrar 1. Decedent's Name (First, Middle, Last)	Ce	rtificate of D	eath		Reg. No. 2	11 38280	
Γ	Physicia Medi		Jerome Irvin Buck				2. Date of De Month 10-30-		ar 3. Time of Death 11:45 P M	
	Exami		4a. Facility Name (if not institution, give street and numb	/	4b. City, Town, or	Location of Deat		4c. County of D		
4,,,,,,,			Hospice Center of Queen 5. Social Security Number 6. Sex 7		Centre			Queen A	Anne's	
	Funeral Director		155-24-9891 1XM2□F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir 10–28–	th g.	Birthplace (State or Foreign Country) PA	
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			****		
	anylar ia-fsl	Director	MD Talbot	Easton	Callon				10d. Inside City Limits 1 ✓ Yes 2 No	
	or 28		10e. Street and Number	Laston	10f. Zip Code			10g. Citizen of What		
	with s 23a ust b	Funeral	29781 Beall Drive		2160	1		USA	. Country:	
	death item		11. Marital Status 12. Was Deced		Was Decedent of His If Yes, specify Cuban	panic Origin? (St	pecify Yes or No-			
036	s after 'al", or Exami	d by	1 Never Married 2 M Married 1 M Yes 2 If Yes, Give Year or Date	2 □ No	1 ☐ Yes 2 🔀 No		o nicari, etc.)	Black, W Specify: W		
2-0	hour	Completed	15. Decedent's Education	16a. Deced	dent's Usual Occupa			16b. Kind of Busine	ses Industry	
21	nin 72 ne. han " e Mec	Juo	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4	life D	kind of work done du O NOT use retired)	uring most of wor	king	Tob. Tally of Edulite	ass made y	
7	d with dygier ther t	Be C	12	Warde	n			New Jerse	ey Prison Sys.	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	고 B	17. Father's Name (First, Middle, Last) Albert Buck				ne <i>(First, Middl</i> e, chaeffer	Maiden Surname)		
lary	and Mandis ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street ar.			r, City or Town, State,	Zip Code)	
Σ,	nd 2 (ealth m 27		Peggy Joyce Buck (Wife)		l Beall D				, ,	
Baltimore,	ge 1 a nt of H : If ite or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from S	20b. Place of Dispo cemetery, cren	natory or other place,		Date	20c. Location - City	or Town, State	
퍞	artmer artmer ortant injury		4 Donation 5 Other (Specify)	Tilghmane			-2011	Tilghmar		
Ba	Depar Impo any ir		1. Signation of files	W (FSN) }	Name and Address ellows, H 00 S. Har	otFacility elfenbei rison St	in & New	nam Funera n MD 21601	1 Home, P.A.	
П			23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	used the death. Do not ente	er the mode of dying,	such as cardiac	or respiratory an	est,	Approximate	
,	h sician/		Immediate Cause (Final disease or condition	i	MALE				Interval Between Onset and Death	
	Medical Examiner		resulting in death) Due to (or	as a consequence of):						
H		ner	Sequentially list conditions, if any, leading to immediate Due to (or	as a consequence of):						
	uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events c.							
	e exec	E E		as a consequence of):						
09	certificate be executed nding physician and use as the burial-transit	dical	d						<u> </u>	
89	ding	/We	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco	me of pregnancy						
Box	death o	Physician/M	in the past 12 months? 1 ☐ Live Bir 1 ☐ Yes 2 ☐ No 4 ☐ Pregnar	th 2 🗌 Fetal death 3 🗌 nt at time of death 5 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year	
	t the d by the tacher	Phys	g ☐ Unknown 9 ☐ Unknow							
ر. ت	requires that the death certific been signed by the attending I should be detached for use as	þ	Part II. Other significant conditions contributing to deal	h but not resulting in the ur	nderlying cause giver	n in Part I.			to the cause of death?	
ord G	requir been s	etec							Probably 4 ☐ Unknown	
Vital Records,	e has l	Completed by					24a. Was a autop perfor	sy prior t	autopsy findings av <i>a</i> il <i>a</i> ble o completion of cause of ?	
	an; Ir tificat tor, pe		25. Was case referred to medical		26 Place	e of Death (Chec	1 🗆 Yes		/es 2 □ No	
X	nysici nis cer i direc	일	examiner? 1 Yes 2 No Hospital: 1 Inp	patient 2 - ER/Outpatient	Oale			ence 6 X Other (So	ecify) Hospice	
TOL	ing Pl		27. Manner of Death 28a. Date of i		28c. Injury a work?			ow injury occurred		
SION	ttend death stor: A r the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		M 1 🗆 Ye	es 2 🗆 No				
DIVISION OT	al or A s after Il Direc		4 ☐ Homicide determined 28e. Place of building,	Injury - At home, farm, streetc. (Specify)	et, factory, office		28f. Location (Si City or Town	reet and Number or F n, State)	Rural Route Number,	
11000	To the rooping or Arendring Prystolan; The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier (Check 2 Medical Examiner: On the best	of examination and/or investi-	gation in my opinion	death occurred at	t the time date or	d place and due to th	a causalet and manner etated	
4	ithin 2 o the	— r	only one) 3 Certifying Nurse Practioner: To t	ne best of my knowledge, de	eath occurred at the ti	me, date and plac	ce, and due to the	cause(s) and manner	as stated.	
F	- > - 0		· and	· Ms	1	5 // 3		9d. Date signed (Mor		
		-	30. Name and address of person who completed cause o	f death (Item 23a) (Type, Pr						
10	9 + VA		Jorge Abrego, M	D 599	8 Cyni	mood	Drive	2, Easto	n MD 21601	
	State Registra	e r	31. Date filed (Worth, Day, Year) 32. Fegis NOV 0 2 2011	f death (Item 23a) (Type, Pr	enter			J	,	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11.08AM 2011 Bessie C. Barranger Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore nes Hospita If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 🚜 F Months Hours Country) Indiana **Director** 265-42-8573 79 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Director 1 Yes 2 No MD Ellicott City Howard 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 4306 Cross Country Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 Never Married 2 Married þ Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ <u>Professor</u> Psychiatric Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Department of Health and Ment. Important: If item 27 is markany injury or any injury o Walter Flowers Bernice Mock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George H. Barranger/husband 4306 Cross Country Drive Ellicott City, MD 21043 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1x Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 11/16/2011 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Ind 21. Signature of Funeral Service Lice 4112 Old Columbia Pike Ellicott City, MD 21043 Manuta thomas 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Sho de Physician/ otic 4 /00 disease or condition Medical resulting in death) Due to (of as a consequence of): **Examiner** tract sinan Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year P.O. signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No has certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death,

To the Funeral Director: After
completed filled in by the funer 5 \square Pending 1 Natural 2 Accider work?
1 Yes 2 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 (Check within 2 only one) 29b. Signature and little of certifier St. Agnes Hospital, 900 Caten Are, Baltimore MD Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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RRAN

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MD kegistrar's Signature

NOV 1 4 2011

11-08730

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For State Registrar	Certifica	ate of Death	Re	g. No. 201	1 3828
Physicia	an/	Decedent's Name (First, Middle,Last)			Date of Deat Month	Day Year	3. Time of Death
nedical Exami	ner	Steven David Banik 4a. Facility Name (if not institution, give street and number	r)	4b. City, Town, or Location of Dea	November	19, 2011 4c. County of Death	2341 hrs
		Calvert Memorial Hospital	,	Prince Frederick		Calvert	
Funeral		5. Social Security Number 6. Sex 7. As	ge (In yrs. last birth			h (MM/DD/YYYY) 9. Bir Foreig	
Director		575-31-5668 1XM 2 F	26	Yrs. Months Days Hours Mi	n. 06/26/		untry) HI
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Limits
E .		MD Calvert	Sunde				1 Yes 2 No
faryland 28a-f show	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cou	ntry?
the M		1136 Lake Ridge Drive		20689		United Sta	ates
th with	eral	11. Marital Status 12. Was Deceden Armed Forces Married 2 Married Armed Forces		 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 		14. Race - Ameri White, etc.	can Indian, Black,
er dea	ᆲ	1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	2 X No	1 Yes 2 X No specify:		Specify: W	nite
turs aft	à	or Dates:		Decedent's Usual Occupation (Give kind of		16b. Kind of Business/l	ndustry
6 172 ho	ete	Elementary/Secondary (0-12) College (1-4 or	5+) du	luring most of working life. DO NOT use re	tired)		
with:r	Completed	12 1 17. Father's Name (First, Middle, Last)	Cor	mputer Repairman	e (First, Middle, N	Computer	
215-0036 be filed with:n 7 ntal Hygiene. rked other tion ent, the Medica	BeC	David L. Banik		Mona M		laideir Surriame)	
2 a % a 2	P	19a. Informant's Name/Relationship (Type, Print)		. Mailing Address (Street and Number or			
MD and 2 sho alth and 27 is raumati		David L. Banik / Father		136 Lake Ridge Driv	e, Sunde	rland, MD 2	
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 Burial 2 Cremation 3 Removal from St	tate cremator	ory or other place)			
Itimair. Pagurtment Pa	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Lee Cr	rematory 11, 22. Name and Address of Facility Le	/23/2011	Clinton,	MD
Derm Depri		CARY J. GOEP		8200 Jennifer Lan	e, Owing	s, MD 20736)
Physician /Medical	T	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not	enter the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
aminer		Immediate Cause (Final disease or condition resulting in death) a. Cardiac A Due to (or as a cons		a			Death
		5 5 5 6 7 6 4 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6		sinoatrial nodal an	tery		
	ne	If any, leading to immediate cause. Enter Underlying Cause	equence of):				
_ =	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a cons	equence of):				1
xecute n and - trans	ᇙ	d. AMENDED 23a	-h ner m	ne,g924 2-7-12 sm			
50, te be ex tysician	Medical	IF FEMALE: 23c. If yes, outcome and the second seco		1C, 6724 2 7 12 Sm		23d. Date of delivery	
2 5 2 A	€ le	1 1 210 122.	ine of programmy				
68 ertifi ding e as t	E	3b. Was decedent pregnant in the past 12 months?	2[=	ancy	Month D	ay Year
30x 6876 death certificate e attending phy I for use as the I	ysician	3b. Was decedent pregnant in the past 12 months?	2 [t time of death 5 [Fetal death 3 Ectopic pregn Other (Specify)	ancy	Month D	
the of	Physician	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	t time of death 5		23e, Did tot	pacco use contribute to	he cause of death?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 38283 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 November 3:52 A M Hazel Booth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Wicomico Nursing Home Salisbury Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months 07/04/1917 West Virginia 217-36-9644 Director 94 Usual Residence of Decedent 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 900 Booth St. 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Force þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify 3 ★ Widowed 4 □ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Andrew S. Morgan Rebecca Lester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Andrew Booth/son 8402 Hilda Dr., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Salisbury Crematory 11/11/2011 Salisbury, MD 21. Signature of Funeral Solvice Licensee Holloway Funeral Home Professional Association Estor Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) ¹Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami executed and tran Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month 1 Yes 2 No Pregnant at time of death the 9 Unknown g 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 þ Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available has autopsy perform prior to completion of cause of death? page 2 this certificate Yes 2 No 1 Tyes Be 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 \ atural 5 Pending М Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SIC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 Eastershore Dr Salisbury, MD Thimmarayappa M.D. egistrar's Signature State NOV 08 2011 Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Candy L. Blakey November 14, 2011 /Medical 5:10 4a. Facility Name (If not institution, give street and number) Examiner Center 4b. City, Town, or Location of Death 4c. County of Death Kensington Nursing & Rehabilitation Kensington Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 25, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🖾 F Months Days New York 52 Director May 075-44-5450 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits Examiner must be notified at Director 1 ☐Yes 2 ☐ No Maryland | Montgomery Kensington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 Mccomas Avenue Funeral 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛛 No þ 3 ☐ Widowed 4 Divorced Specify: African American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DC Public Cafeteria Staff 7 is marked other traumatic event, II Schools Systems 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) William V. Blakey ပ Kitty Stubbs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tahesia Taylor - Daughter 3076 Stanton Road # 103 : If item 27 Washington, DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Important: If any Injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) lees crematory matory 11/28/2011 Washington 22. Name and Address of Facility Stewart Funeral Home, Inc. Washington, DC 21. Signature of Funeral Service Licensed 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** athero Sclerotic Cardiovascular disease or condition resulting in death) Unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death in the past 12 mon 3 Ectopic pregnancy Month 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The certificate Melli' Las Division of Vital 1 ☐ Yes 2 - No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 10 No Certification: To t ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) After t 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ithin 24 hours after death.

The Funeral Director: Afformpletely filled in by the fur 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 0 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) hrewde

State Registrar

DHMH 17 Rev 1/2001

605 Main Street, Laurel,

30. Name and address of person who combed cause of death (Item 23a) (Type, Print)

HURY, MD,

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Division of Vital Records,	the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death. In 24 hours after death. Thin 24 hours after death. The thoreal becator: After this certificate has been signed by the attending physici mpleted filled in by the funeral director, page 2 should be detached for use as the but the but the bound in by the funeral director.		4 ☐ Homicide determi	ino, rann, ouc	or, idotory, omco		ľ	City or Tow			or nura	i noute warnibe	<i>H</i> ,		
	To the Hospital within 24 hours a To the Funeral D completed filled i	Medical	(Check 2 L. Medical E:	Physician: To the best of xaminer: On the basis of each	camination	and/or investi	gation, in my opinio	on, death or	curred at t	he time date a	and place	e and due to	o the ca	suse(s) and man	ner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 38286 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0828AM Ernest Brittingham 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Micomic formsula Pagional Madical Center allsbur Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days (Month, Day, Year) 216-14-9321 **Director** 1 **X**M 2 □ F 87 11-26-1923 MD 28a-f show items 23a or 28a-f sho her must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Worcester Pocomoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1625 Colona Road 21851 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. or. þ 1 Never Married 2 Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. SpeBlack "natural" Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Sanitation Campbell Soup Co <u>Department</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Lloyd Brittingham Louise Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June A. Roberts/Daughter Colona Road, Pocomoke City, MD 21851 1625 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-5-2011 Pocomoke, MD <u>James</u> Cem Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Home Salisbury. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ anema disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-trans Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical death certificate be Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached P.O. To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? certificate 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 🗌 Yes 2 1 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death hours after death.

uneral Director: After the fulled in by the funera 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral I

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) 30. Name and address of person who comple 100 E. Carrollst Salisbury mD 2180) Simona P.R. M.C 40

Registrar
DHMH 17 Rev 06-2011

State

Registrar's Signatur

4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Funeral		5. Social Security Number 6. S	ex 7. Age (In yi	s. last birthday)	If Under 1 Year	Birthplace (State or Foreign					
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21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	I .	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🖾 No		to Rican, etc.)	Specify: A			
15-(72 hou n "natu edica	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occupa		rking	16b. Kind of Busines	ss Industry		
712	vithin jene.		Elementary/Seconday (0-12) 12th	College (1-4 or 5+)	life. D	O NOT use retired) Clerk			Central II Ager	ntelligence		
pu	filed val Hyg	Be C	17. Father's Name (First, Middle, Last)	·			18. Mother's Na	me (First, Middle,	Maiden Surname)	10)		
Maryland	should be filed within and Mental Hygiene. 'is marked other tha raumatic event, the N	욘		Richardson				Mary Hu				
Mai	2 shorth and 27 is rutraum		19a. Informant's Name/Relationship (T Marsha B. Smith	• • •		ng Address (Street a cair Aven			er, City or Town, State, arv land 2(Zip Code) 0785		
re,	of and 2 should be of Health and Mente fitem 27 is marked rother traumatic e		20a. Method of Disposition	201	n Place of Dispo	sition (Name of		Date	20c. Location - City			
Baltimore,	Page ment cant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Marylan Cem	natory or other plac d Veterar etery	ns Nov	. 21, 2011	Cheltenha	m, Maryland		
Balt	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signature of Funeral Service Licens	Stewar	22 22	. Name and Addres	s of Facility St		uneral Hom	e, Inc.		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	olications that caused the d						Approximate Interval Between		
	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)			ac Arrhyt	hmia			Onset and Death		
4	Examiner			Due to (or as a cons	equence of):							
	- +	iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):							
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0	certificate be executed inding physician and use as the burial-transit	dical F	in data, past	d	04001100 01/1							
8760	ifficate ng phy as the	Medi	IF FEMALE:	u								
Box 687	es that the death certific igned by the attending p be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live Birth 2 F	etal death 3	Ectopic pregnanc	у		23d. Date of o			
. Bo	he death y the atter ched for o	nysic	1 Yes 2 X No 9 Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5 L	Other (specify)			Month	Day Year		
P.O.	that the		Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?		
rds,	v requires been sig should b	ted						1 🗆	Yes 2 ☐ No 3 ☐	Probably 4 🖾 Unknown		
100E	law re has be re 2 sh	Completed by						24a. Was autor	an 24b. Were a prior to death	autopsy findings available o completion of cause of		
E B	sician: The la certificate ha rector, page		25. Was case referred to medical			DC DI		1 Yes		es 2 🗆 No		
Vita	Physicia this cert al direct	To Be	examiner? 1 ☐ Yes 2 🔼 No	Hospital: 1 Inpatient 2	☐ ER/Outpatien	Otho	ace of Death (Che r: 4 Nursing F		dence 6 Other (Sp	ecify)		
οί	ling PI		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at		now injury occurred			
Sior	l or Attending after death. Director: After I in by the fune.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		home farm stre		Yes 2 No	28f Location /9	Street and Number or F	Rural Route Number		
Division of Vital Records,	tal or / s after al Dire		4 ☐ Homicide determined	building, etc. (Spec	cify)	, , , , , , , , , , , , , , , , , , , ,		City or Tow		iara mode wamber,		
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 L Medical Exami	ician: To the best of my knoner: On the basis of examina e Practioner: To the best of	tion and/or invest	igation, in my opinio	n, death occurred	at the time, date a	ind place, and due to th	e cause(s) and manner stated.		
: !	with to the control of the control o		29b. Signature and title of certifier		29c. License			29d. Date signed (Mor				
			20 None and - (1)		D		065914		November 1	5, 2011		
1/	2 10		30. Name and address of person who de Amy Schiffman, MD			,	rive Ro	ckville,	Maryland	20850		
	Stat Registra	e ir	31. Date filed (Month, Day, Year) NOV 1 6 2011	32. Register's Sig	ack							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 Judson William Bailey 2011 03:47A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice at the comi Shur . Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{Year)}930 1 X M 2 🗆 F Days Hours Aug 10, 231-32-2697 Director 81 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🗔 No MD Wicomico Salisbury ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1607 Towson Avenue 21801 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates, ретліt. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 African-1 Yes 2 No Specify: 3 Divorced Completed American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Owner Taxi Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hodie Bailey, Sr. Viola Newton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola Bailey/wife 1607 Towson Avenue, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Springhill Memory any injury or 4 ☐ Donation 5 ☐ Other (Specify) 11/05/2011 Hebron, MD Cardens 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd. Salisbury, MD 21801 Salisbury, MD 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 🗌 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 No Yes 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death Time of 28c. Injury at work? Certificate: Natural Natural injury 5 Pending s after death. Accident Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29c, License number D63199 ddress of person who completed cause of death (Item 23a) (Type, Print) 04 VOHRA 910 SALISBURY EASTERN SHORE

Registrar

State

31. Date filed (Month, Day, Year)

NU

32. registrar's Signature

MANA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 38289 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 7:04 AM Martha Lelia Bratten 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Archie Dennis Road Parsonsburg der 1 Year | If Under 24 Hrs. Wicomico 9. Birthplace (State or Foreign Country) Virginia Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, **Funeral** 1 M 2 XF Days Months Min Yrs **Director** 79 217-28-4900 1 - 1 - 193Usual Residence of Decedent 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗆 Yes 2 🗓 No MD Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 6991 Archie Dennis Road 21849 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 X Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White "natural" Completed 3 Widowed 4 Divorced Specify. the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. 10 Seamstress Shirt Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever age 1 and 2 should be fillent of Health and Mental out if item 27 is marked or y or other traumatic ew ပ Robert Hornsby Eunice Davenport 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Bratten - Husband 6991 Archie Dennis Road, Parsonsburg, Maryland 21849 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 \square Cremation 3 \square Removal from State Department of Important: If any injury or Pittsville Cemetery 11-7-2011 Pittsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility gnatu of Funeral Service Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Fh sician/ ment disease or condition Medical resulting in death) as a consequence of Examiner ardiomygratty Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequer or of) signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year Pregnant at time of death Yes 2 1 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy reast cance ☐ Yes 2☐ No 1 Tes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t To Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 - No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State, Medical Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 1538 NOV. 4, 2011 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) SALISBURY MD KODNEY WENRICH, M.D. 1346 S. DIVISION ST. 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State NOV 07 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Merle Gilbert Barlup November 21, 2011 3:33 P. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death
Washington Smi thsburg 22014 Beaverbrook Dr. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Feb. 15, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🖁 M 2 🗆 F 217-10-3247 93 Mary land **Director** 1918 Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Bant If item 2.23 or 28a-1 show that If item 2.75 is marked other than "natural", or items 2.3a or 28a-1 show jury or other traumatic event, the Medical Examiner must be notitied at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Washington Md. Smithsburg 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21783 U.S.A 22014 Beaverbrook Dr. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iten edical Examiner r 14. Bace - American Indian Armed Forces Black. White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Agent Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sophie Walters Phillip Keller Barlup 19a. Informant's Name/Relationship (Type, Print)
Evelyn M. Barlup (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22014 Beaverbrook Dr. Smithsburg, Md. 21783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1.8
Department of Important: If it any injury or of once. Noy 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Smithsburg,Md. Smithsburg Crematory 2011 Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. NIS Davis Funeral Home Smithsburg, Md. 21783 M01414 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Cormer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Criter Orderlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): and trar Due to (or as a consequence of) resulting in death) Last physician a sthe burial-1 Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2 No Yes 2 N 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29 a State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38291 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 16, 2011 Physician/ Κ. Bradstock 2:00 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Vindobona Nursing Home Braddock Heights Frederick 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 288-12-4849 **Director** 1 □ M 2 💢 F 93 07/10/1918 Ohio 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 3a or 28a-f sh t be notified a 1 🏋 Yes 2 □ No Frederick Frederick 10e. Street and Number 10f. Zip Code r must b 10g. Citizen of What Country? Funeral 21701 United States 11 East Third Street items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo , or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 XWidowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) 5+ if Health and Mental Hygiene. item 27 is marked other that other traumatic event, the Inferior other o Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Metta Marsh Alvin J. Kunsman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 East Third Street, Frederick, MD 21701 Janet Bradstock / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Donation 5 11/29/2011 | Kent, Ohio Standing Rock Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition My occultail Interche Medical resulting in death) Due to or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No signed by the at Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Driberts Mullips 1 Yes 2 No 3 Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director, After this certificate 1 ☐ Yes 2 No Yes 2 No funeral director, To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 **X**No မ 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 \sum Yes 2 \sum No 5 Pending iniurv 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 11/16/11 D43780 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3005, church St. Mildleton MD 21769 Kevm E. Hoh/ms Po Sex 20 31. Date filed (Month, Day, Year) State DEC 0 1 Registrar

DX

38292 State of Maryland / Department of Health and Mental Hygien 20 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death **Physician** neryl 10800145 NOV. 21,2011 7:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS WALDORF CHARLES CENTER WALDORF If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 8-22-1955 9. Birthplace (State or Foreign **Funeral** Months WASH., D.C. 220-66-7533 56 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits MD. ANNE ARUNDEL UPPER MARLBORO 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 9307 NORTHVIEW ROAD 20774 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE Be Completed by 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filment of Health and Mental Hent: If item 27 is marked oth jury or other traumatic even LEE BROOKS ANNA G. DEANS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JASON R. ANNABLE-SON 9307 NORTHVIEW RD. UPPER MARLBORO, MD. 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o importent: if eny injury or once. METROPOLITAN CREMATORY 11-23-11 ALEX., VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SE
LA PLATA, MARYLAND 21. Signature of Fyneral Service Licensee M00479 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lives stage FIND **Physician** /Medical Due to (or as a consequence of): Examiner Cityhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4☐Pregnant at time of death signed by the at d be detached for 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Nnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Esophageal Jasias 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Denu 2 **X** No 1 🗆 Yes 21 No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death Check only or e Hospital: 1 Yes 2 No Other: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) illed in by the funeral 27. Manner of Death 28d. Describe how injury occurred 5 Pending Natural 2 Accident investigation within 24 hours after death.

To the Funsrel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Fo the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31 heted cause of 2007 Tidewall Colony Brice IA, of death (Item 23a) (Type, Print) Annayous, mo. State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38293 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Philip November 6:48 Baker Brown Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Aug. 12, Year 1933 220-28-7749 Maryland Director 78 Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 1 ☐ Yes 2X No MD Washington Clear Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important If item 27 is marked other than "... any injury or other traumati-Funeral U.S.A. 10820 Garrison Hollow Rd. 21722 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces'
1 X Yes 2
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 2 No 1 ☐ Yes 2 K No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Automotive Elementary/Seconday (0-12) College (1-4 or 5+) Inspector Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Franklin Brown Marion Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, P. Gregory Brown/Son 17217 W. Washington St., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 11/26/2011 Hagerstown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such, s cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequ Exami -tran pue resulting in death) Last Due to (or as a conseque burialphysician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as ding IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant atten for us 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 2 No the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩iknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas page 2: performed certificate 2 🗌 No Yes 2 1 🔲 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA this 4 Nursing Home 5 Residence 6 Other (Specify) funeral hours after death.

uneral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined e Funeral ? Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie completed (Chec)

State Registrar 3 [

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Da

DHMH 17 Rev 7/2009

within 2.

BDORU

32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

045031

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink ց երջ երջ կեր գրվե արվա I tem 3 per ined in black Indelible Ink ց երջ երջ կեր գրվան Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 14, Year 01 Physician/ Month 8:55 p M November Medical Randall L Clark 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Washington Assisted Living <u> Hagerstown</u> Autumn If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Hours Month Day Virginia Director 232-45-9430 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗆 No MDWashington Hagerstown 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 21740 USA 310 Cameo Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married <u>\$</u> Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic executions. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Telegram Exchange Lineman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carmen V. Stotler Gordon L. Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Brother) Dennie Clark 123 GlenGary Rd. Winchester, VA Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 11/17/2011 Whitacre, VA Signature of Funeral Service License 22. Name and Address of Facility Flacture. Giffin Funeral Home Inc. Capon Bridge WV 26711-010 M0103 26711-0100 Box 100 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ a ARTERIOSCIEROTI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence or). Exami Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, DEMENTIA, HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed this certificate 1 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? HUT LIVE Other: 4 Nursing Home 5 Residence 6 2 No ٩ Other (Specify) ASSISTED LIVING 1 Inpatient 2 ER/Outpatient 3 IDOA 24 hours after death.

Funeral Director: After thi leted filled in by the funeral. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 1 Natural
2 Accident 5 Pending Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) MO 15. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T/11-2 340 mill HALERSTOWN MD egistrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Collins 8:30 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Healthcase ulia Manop Center Haverstown Washington 8. Date of Birth
(Month, Day, Year) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign 1 XM 2 □ F Director 335-10-6638 92 1919 Usual Residence of Decedent 10a. State 10b. County Ħ 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Maryland Washington County Hagerstown 1 ☐ Yes 2 XNo 10e. Street and Number ems 23a or r must be r 10f. Zip Code 10g. Citizen of What Country? by Funeral 19838 Jefferson Blvd. 21742 U.S.A. items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces2...
1 X Yes 2 No If Yes. Give 1944— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian injury or other traumatic event, the Medical Examiner Black, White, etc. ō 1 Never Married 2 X Married 1 X Yes 2 No 1 Yes, Give 1944— Year or Dates. 1945 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Farm Implement Co. 12 Chief Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Frederick Collins, Sr. Helen Higgins Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co Roger Collins-son 19838 Jefferson Blvd. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 11-14-2011 Smithsburg, MD permit. f Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Httwcosclerot disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last iabetes and burial-trar ue to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Unknown Year ed by the detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy perform 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 🗶 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2. only one) 3 🕱 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Barbara R125360 11/14/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month

15

Mill Street Hacenstown

RNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Robert W. Clayto	on	State of Maryland / Department o 1-For State Certificate o			and	Menta	l Hyg		Reg. N	. 201	1 38296
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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	٦	If Under 1	\rightarrow	If Under 2		8. Date of E	Birth (N		rthplace (State or
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72 hours after death with the Maryland n "natural", or items 23a or 28s-f she all Examiner must be notified at once	Ē	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was		Decedent of	f Hispa	nic Origin?		cify Yes or N		14. Race - Ame	rican Indian, Black,
death	Funeral	1 Never Married 2 X Married Armed Forces? If Yes 2 No	Yes	s, specify C	uban, N	lexican, Pu	uerto R	can, etc.)		White, etc.	
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Baltimore, Dermit. Pages 1 as Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or of 4 Donation 5 Other Specify: Stauffer			0217			ember 2011	$ _{\mathbf{F}}$	rederick.	Maryland
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n of Vital Records, P.O. Box 6876 ding Physician: The law requires that the death certificate n After this certificate has been signed by the attending phy finneral director, page 2 should be detached for use as the l	Į.	Part II. Other significant conditions contributing to death but not resulting in the	uno	derlying cal	use give	en in Parti.	'				bably 4 V Unknown
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COT law rather has be	Completed							per	opsy form <u>ed</u>	? death?	completion of cause of
Vital Rec ysician: The his certificate director, page		25 Was case referred to medical		26 F	Place of	Death (Ch	eck on	1 Yes	2	No 1 ✓ Y	es 2 No
Vita hysician this cer	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	nt :			hor =		Home 5	Res	idence 6 🗹 Othe	er: Scene
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ttendi death.	atio	Natural 5 Pending Pending Investigation fd 11-12-11 fd 14:		5		2 X No	\perp	nknow			
Division of Vital Records, pital or Attending Physician: The law requir ours after death. reral Director: After this certificate has been sifiled in by the funeral director, page 2 should	Certification:	3 Suicide 6 X Could not be determined (Specify)			ice buil	ding, etc.		or Town,	State	6057 Mour	ural Route Number, City nt Philip Rd
lospita hours uncra		29a. Certifier 1 Certified Physicians To the heat of my knowledge death accurate		100	e date	and place		Frede			- Led
Division To the Hospital or Attentil within 24 hours after death. To the Funeral Director: A	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation									
T wi.	Me	and manner stated. 29b. Signature and title of certifier		29c. Li	cense n	number			29	d. Date signed (Mo	onth, Day, Year)
		(arae Hallace		0	.C.M.	E.			N	ovember 13, 2	011
20H	-	30. Name and address of person who completed cause of death (Item 23a)	141	more CI-	204 12	altim	, AID	21222			
	مئد	Carol Allan, MD Assistant Medical Examiner 900 W. Bal 31. Date filed (Monarchar Year) 32. Registrar's Signature	un	nore Str	eel, B	ailimore	, IVID	21223			
St Regist	ate	31. Date filed (Month Per, Year) 2011 32. Registrar's Signature	Z.	1 Carren							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38297 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 112 AM Cormier Edmond F. Sr. Medical 4a. Fa**gin**ty Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** tospice Jahsbur Comico 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours 79 **Director** 216-28-8441 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Salisbury Maryland Wicomico 1 Yes 2 K No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 4588 Nutters Cross Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. X Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Navy Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Salesman Cigars Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Catherine Hayes Edmond E. Cormier dmund 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Cormier/Son 1603 S. Division St., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Salisbury Crematory 11/8/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ke Carcinome Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, If any, returning to immediate cause. Enter Underlying Cause (Disease or linjury Examine Duy to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of al Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D63199. 11/6/11. ute s of person who completed cause of death (Item 23a) (Type, Print) YOGESW BR. SALISBURY, MD, ZI80 4. OHRA 910 EASTERN SHORE 31. Date filed (Month, Da istrar's Signature State

Registrar

11-08508 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James Edward Coleman, Jr State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day November 12, 2011 1052 hrs James Edward Coleman Jr. **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8108 Rydal Road District Heights Prince George's 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** oreign Country) Months Days Hours 22 01/30/1989 Director 213-35-2767 1 M 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 1 X Yes 2 No s 23a or 28a-f show e notified at once. Prince George's Capitol Heights Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho
injury or other trannatic event, the Medical Examiner must be notified at once. rector 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 1420 Opus Ave United States 苬 Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces' Yes Black 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Professional Mover Private 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jocelyn Tharps James Edward Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1420 Opus Ave, Capitol Heights, MD 20743 Jocelyn Tharps/Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 11/17/2011 Clinton, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Pope Funeral Homes, P.A. Signature of Funeral Servis Licensee 5538 Marlboro Pike, Forestville, MD 20747 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and trans ca UNPENDED AMENDED attending physician for use as the burial Physician/Medi Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. <u>8</u> 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? . death? ✓ Yes 2 No certificate 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 Yes After 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Nov 12, 2011 Shot by police 1040 hrs 1 Yes 2 🗸 No Pending in by the Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 8108 Rydal Road, District Heights, MD completely filled 4 V Homicide (Specify) Driveway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 13, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Year) 32. Registrar Signaty State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Arely Rodriguez Castillo Medical Novembe 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) ACAPLILCO de Juarez 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min. Days 1 ☐ M 2 🛣 F 1170771985 Yrs **Director** 26 N/A Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director must be notified Rosarito Baja California, Mexico 1 ☐ Yes 2 🖺 No 10e. Street and Number Miguel Col. Morite Carlo Hidalgo Playas o 9 10f. Zip Code 10g. Citizen of What Country? de Rosarito Funeral items 23a Mexico Baja California, none <u>Mexico</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ò Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1⊠Yes 2□No Specify: Hispanic "natural" 3 Divorced Specify: Hispanic Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private 12th Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Reina Castillo de Rodriguez Bertin Rodriguez Abundiz 19a. Informant's Name/Relationship (Type, Print) -Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Miguel Hidalgo, #3301 Col. Morite Carlo Playas
de Rosarito, Baja California, Mexico Reina Castillo de Rodriguez 20b. Place of Disposition (Name of cemetery, crematory or other place)
Panteon Municipal de
Playas de Rosarito 20a. Method of Disposition 20c. Location - City or Town, State Rosarito Baja 1 X Burial 2 ☐ Cremation 3X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/23/2011 California, Mexico 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, Charle 5538 Marlboro Pike, Forestville,MD 20747 23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one conse on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) BACTEREMIA Day Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of). to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Myeloid Leukemia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes Be Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗌 Yes 2 🗌 No Accident Suicide Investigation Could not be 6 🗌 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certific 29d. Date signed (Month, Day, Year) ME106688 November 14, 2011 who completed cause of death (Item 23a) (Type, Print)

Registrar

State

10 Center Drive, Bethesda, MD 20892

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. - For State Registrar State of Maryland / Department of Health and Mental Hygiene 38300 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11,2011 Earl Collins November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Prince Georges Cheverly . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 245-56-4294 1 🕅 M 2 🗆 F 68 Usual Residence of Decedent Dec.14,1942 NC 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PG Capitol Heights Street and Number 10g, Citizen of What Country? Funeral 1213 Abel Avenue 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. by 1 Yes 2 XNo If Yes, Give 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Printer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Collins Henrietta Starkey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1213 Abel Avenue 19a. Informant's Name/Relationship (Type, Print) 213 Abel Avenue Velma Collins/wife MD Hei 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 11/18/11 Suitland, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H.Hill Rd., Suitland, MD, 20746 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ORON AM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence Exami a ending physician and The law requires that the death certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate Yes 2 No Yes 2 V No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury filled in by the Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and At 29d. Date signed (Month. Day, Year) D63688

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300

Hospital

Drive, Cheverly,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11 24^{Day} Helen P. Caton 2011 2:00AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS Frostburg Nursing & Rehab Center Frostburg Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 - M 2 X F Hours Min. 213-22-4159 Director 03-25-1924 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner muss be a single once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Frostburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17 Meshach Frost Village 21532 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Sewing Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lewis Hovman Rebecca LaRue Hoyman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Willison daughter 17 Meshach Frost Village Frostburg, MD 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Zion Cemetery 11-27-2011 Frostburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, P.A. Frostburg, MD 21532 Twee MO054 60 W. Main St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ cule cemis disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, ner day, leading to in reducts cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for sela consequence of: Examir Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Pregnant at time of death Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed certificate has been si irector, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital 2 1 No ျှ 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pendina within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident 1 🗌 Yes 2 L No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year)

DIL

Registrar
DHMH 17 Rev 7/2009

State

Walsh

925 Bishon

32. Registrar's Signature

Carlo Carlo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year)

WL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month RIRAM 0825 M 2011 Medical 4a. Facility Name (if not institution, give street and number, County of Death **Examiner** 4b. City, Town, or Location of Death aurel Regional Hospital Prince George's Laure Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 1 X M 2 D F Months Hours Director 45 437-71-1051 1965 India Dec. 28 "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director VA Fairfax Vienna 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 713 Upham Place 22180 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married Completed by Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) V.S. Chakrapani Vijaya Krishnaswamy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Deepa Chakrapani /Wife</u> **221**80 713 Upham Place <u>Vienna,</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2X Cremation 3 ☐ Removal from State Adams-Green Funeral Home Herndon, VA 4 ☐ Donation 5 ☐ Other (Specify) 11/22/2011 . Signatur 22. Name and Address of Facility 721 Elden St. Adams-Green Funeral Home 20170 Herndon, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ ente disease or condition resulting in death) 90min Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available 24a. Was an autopsy prior to completion of cause of perform death? After this certificate 2 No 1 Yes Yes 2 To Be 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) 1 Yes 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier D54223 November 18, 2011 7300 Van Dusen Rd. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel, MD 20707 Thuan Regional Hospital Laurel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day CHRISTIANSEN FRANCES WELLS Nov 79 201 12:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Autumn Assisted Living Cockeysville Baltimore 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Min. Months Hours Country) nnsvlvania 160-05-0695 Director 93 Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. 1 🗌 Yes 2 💢 No Harford Fallston 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3248 Charles 21047 Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces' 1 Never Married 2 Married Completed by Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced White Year or Dates al Hygiene. I other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Education other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H 2 should be Edgar Wells Dunwiddie Edna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21047 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jennifer M. Stevens (Dau 3248 Charles Street Fallston, Maryland Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov Date 22, 1 M Burial 2 Cremation 3 Removal from State Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) High iew Mem. Gardens 21. Signature of Funeral Service Ligen 22. Name and Address of Facility Kurtz & Son Funeral E.G. Jarrettsville. Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a commune of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the burial Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ctopic pregnancy
Other (specify) in the past 12 months? Month Dav Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown Yes 2 No ed by the a 9 🗌 Unknown P.O. signed k I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has Physician: The law autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 🔀 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

(Check

29b. Signature and title of certifier

31. Date filed (Month, 1)

ans como

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIOES

Begistrar's Signature

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DHMH 17 Rev 7/2009

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

2011

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NO V KAY DAMM Year 201 02:30AM JUNI 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death COLLIER COURT WESTMENSTER ARROLL Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) JAN. 17,1962 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 187-40-7296 1 □ M 2 🔀 F 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e Street and Number 10g. Citizen of What Country? 5 21158 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 XNo If Yes, Give Year or Dates 1 Yes 2 No Specify. WHITE 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname JACQUELINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS NOV. 21,2011 (HANBERIBURL Whelius ture il temerito numeribus Pa 17201 Signatur of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shacely, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death 10 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Month Day Year

Physician/ Medical Examiner

Department of Health Important: If item 27 any injury or other the once.

Physician/

Medical

10a. State

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

28a-f show

27 is marked other than "natural", or items 23a or 28a-f sho r traumatic event, the Medical Examiner must be notified at

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-transit and attending physician for use as the burial signed by the atte within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director,

To the Hospital or Attending Physician: The law requires that the death certificate be

Division of Vital Records, P.O. Box 68760

Examiner resulting in death) Last Physician/Medical IF FEMALE Completed by 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

To Be Certificate:

Medical

29a. Certifier (Check

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify,

28a. Date of injury (Month, Day, Year) 5 Pending Investigation 6 Could not be determined

28b. Time of injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work? 1 ☐ Yes 2 ☐ No

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28d. Describe how injury occurred

address of person who completed cause of death (Item 23a) (Type, Print

24b. Were autopsy findings available prior to completion of cause of death?

1 🗌 Yes

31. Date filed (Month

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38305 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 29-201 1 818 Beatrice Marcella Calvet Doolittle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Apt 114 Easton 700 Port Street If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛱 F 92 Months Days Hours Min. 7-23-1919 NJ Director 118-03-2527 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Easton MD Talbot 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21601 USA 700 Port Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", Specify: White 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Author/Artist 12 4+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Beatrice Eunice Irene Fletcher Marcel Calvert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 Boxwood Lane Englewood, FL 34223 Dane F. Hahn, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Cremation
Center 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11-3-2011 4 Donation 5 Other (Specify) Stevensville, MD Signature of Funeral Service Licens Fellows, Helfenbein & Newnam Funeral Home, P.A. 1200 S. Harrison St. Easton MD 21601 at Jaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications th shock, or heart failure. List only one cause rval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a conseque that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) Day Pregnant at time of death sate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 N 2 🗆 No 1 Yes Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 29b. Signature and title of c

Registrar DHMH 17 Rev 7/2009

State

TLS

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

D25750

508 Idlewild Avenue, Easton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Sanchez, MD

NOV 07 2011

31. Date filed (Month, Day, Year)

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Director	ř	219-34- Usual Residence of 10a. State		1 □ M 2 🗹 F	75	Yrs.		Min. 03/28	8 / 1 :	936	MD 10d. Inside City Limits
should be filed within 72 hours after death with the Maryland and Memtal Hygiene. I am death Hygiene is marked other than "natural", or items 23a or 28a-f sho 'aumatic event, the Medical Examiner must be notified at	Funeral Director	MD 10e. Street and Num		GOMERY	RO	CKVIL	LE 10f. Zip Code		10g. (Ditizen of What C	1 🗹 Yes 2 🗌 No
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than "natural the Medical Ex	Completed by	Elementary/Seco	15. Decedent's cify only highest	Year or Dates.	5+)	16a. Deced (Give k life. Do	ent's Usual Occupation ind of work done during most of NOT use retired) IE EXAMINER	working		Specify: Kind of Busines EAL EST	
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Department of I Important: If its any injury or ot once.			5 Other (Spe	•	ST.	22.	S CEMETERY 1 Name and Address of Facility ILTON FUNERA	1/11/20	1		SVILLE, MD
ysician/ Medical xaminer	ner	23a. Part 1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death) Ecquentially list condition if any, leading to immediate Cause. Enter Underly	t failure. List only Final n	a. Yeg in a Due to (or as	a tov a consequence	Do not ente fai nce of): ructive	r the mode of dying, such as can lure fulmonary d	diac or respiratory a		NESVIL	Approximate Interval Between Onset and Death 6 inwiths decades decades
uris da		Cause (Disease or is that initiated events resulting in death) Life FEMALE: 23b. Was decedent print the past 12 mr. 1 Yes. 2 12	injury ast pregnant nonths?	c	of pregnand	cy death 3 □	Ectopic pregnancy Other (specify)			23d. Date of d	
Id be detached	d by Friys	g Unknown Part II. Other signific	cant conditions	g Unknown contributing to death be zart faily	out not resul	ting in the ur	nderlying cause given in Part I.				o the cause of death?
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Director: After this certification by the funeral director	2	25. Was case referred to medical examiner? 1							iry occurred		
the Funeral Completed filled	Medical	(Check 2 L only one) 3 [☐ Medical Exa ☐ Certifying No	miner: On the basis of e	xamination a	and/or investi	occured at the time, date and place gation, in my opinion, death occurred at the time, date and	ed at the time, date	and plac ne cause	e, and due to the (s) and manner a	cause(s) and manner states stated.
5		29b. Signature and til	ray	completed cause of d	eath (Item 2	3a) (Type, Pr	29c. License number D 36257		N		r 61 2011
State Registrar	3	Steven k		2011 32. Hegistra	5 Co	ncord	St, #500, K	ensing ton	, M	D 208	95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2011 445 -lico 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 6. Sex 8. Date of Birth (Month, Day, **Funeral** 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 060-07-5169 Months Days Hours 1 □ M 2 🖵 F Director New York 92 07/27/1919 28a-f shov 10a. State with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3785 Plum Meadow Drive 21042 United States items ; permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3

Widowed 4 □ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Liberato Cuti Anna Mingone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3785 Plum Meadow Drive Ellicott City, MD 21042 Anna St. Yves/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 🗱 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/16/2011 Bronx, New York Raymond's Ceme 21. Sign of re of Funeral Service L 22. Name and Address of Facility Harry H. Witzke's Family F.H. In atinar 4112 Old Columbia Pike Ellicott City, MD 21043 thoman 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Neumonio Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a nonsequence of, Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year signed by the at Id be detached for Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> stenosis Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has bage 2 s autopsy performe this certificate 1 Yes 2 INO Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ျှ 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 24 hours after death.

Funeral Director: After the state of the state 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Mo

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 38308 Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ 1000 M 05 2011 NOV Medical fif not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death . VICOMICO 544156414 8. Date of Birth If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral Director** 44 1 M 2 V Massachusetts show at 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f Yes 2 No 9 10g. Citizen of What Country? Funeral 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 0 Completed by 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 Yes 2 No "natural", 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Occupational Therapist Healthcare traumatic event, Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) 0 John Clement Cardwell Peggy Lynne Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s nt of Health a : If item 27 i David Dickson/spouse 6089 Setters Court, Salisbury, MD 21801 other Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State ö Department Important: If any injury or Salisbury Crematory 11/8/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Sevice Licensee Holloway Funeral home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cervical Metastatie disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) Year Pregnant at time of death g Unknown 9 Unknown P.O. I þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy perform page 2 certificate | 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) n 24 hours after deaun. ne **Funeral Director**: After this ce noletely filled in by the funeral dire 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of injury
injury
28c. ٥ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of De Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce DC071972 2011 30. Name and addres completed cause of death (Item 23a) (Type, Print)

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Dorothy Jean Davis 9:384 2011 Medical Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death oasta Hosp cit Th 1135ur If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday If Under 1 Year 8. Date of Birth 1 🗆 M 2 🏝 F Months Days Hours 213-24-2427 82 08/30/1929 Maryland Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director Wicomico Fruitland 1 🗌 Yes 2 🍱 No Maryland Ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 406 Tiffany Drive 21826 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Housekeeping Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elizabeth Slaughter Charles Thomas Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Richard Davis Jr./Son 27137 Scotland Parkway, Salisbury, MD 21801 Department of Health Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Wicomico Memorial Park 11/11/2011 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Ę Funeral Service Licensee any ir Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Lenkemia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes No Live Birth 2 Fetal death Pregnant at time of death Month Day Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed No autopsy 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital à □ No 1 🗌 Yes Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 063199 11/6/11 UTC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOGESH VOHRA 910 EASTERN SHORE DR, SALISBURY, MD, 21804,

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38310 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 11-15-2011 Year Juan Francis Dudley аМ 1237 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Numberunk 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Hours 60 Virginia Director Usual Residence of Deceden show or 28a-f shown notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington 1 Yes 2 XNo 10e. Street and Number 10f, Zip Code ö 10g. Citizen of What Country? r items 23a or iner must be r Funeral 648 Chaplin St. SE 20019 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō 9 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural". Completed 3 Widowed 4 Divorced Specify: Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Musician Private permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Belle White Tryine Francis Mattie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16500 Jilrick St. Rockville, MD 20859 19a. Informant's Name/Relationship (Type, Print) Sean F. Dudley/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State 11-22-2011 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Pk Crem. 22. Name and Address of Facility Ronald Taylor II FH gnature of Funeral Service Licensee arras 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician 70 disease or condition Medical resulting in death) Due to (or as a corr equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No 2 1 Yes 25. Was case referred to medical B 26. Place of Death (Check only one) P 1 🗌 Yes 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 🗆 No the f Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) filled in by 4 Homicide determined 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eem Name and address of person who completed cause of death (Item 23a) (Type, Print) Park mD 20912 7600 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMber Fannie Laverne Dallas Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince Georges Lanham If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Days Hours Min. Director 0170371959 Yrs <u>074</u> 50 8546 Columbia, SC Usual Residence of Decedent or 28a-f show 10a. State 10b. County 72 hours after death with the Maryland Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Prince Georges Bowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? or items 23a 15400 Pine Tree Court 20721 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 1 No Black, White, etc þ 1 Never Married 2 Married 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 To No Specify: "natural" Completed 3 Divorced 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) uld be filed within 7 I Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha 12th Security Officer Securiguard Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Benjamin Chavis Alberta Chavis Waiters permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is mark any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) City or Town, Stat 19b. Mailing Address (Street and Number or Rural Route Number, Cit $15400\,$ Pine Tree Ct., Bowie, MD John W. Dallas Jr. Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 11/19/2011 Bladensburg, MD 21. Son ture of Funeral Service 22. Name and Address of Facility John T. Rhines Funeral Home valu rue 12th NEWashington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one-cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ Metastatic Breast Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Acute Respiratory Failure Sequentially list conditions Examine Dire to for as a consequence of, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Anoxic Brain Injury use as the burial-trans Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Shock Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year been signed by the should be detached g K Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Bilateral Pneumonia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Metastatic Brain, Lung and Liver Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Yes 2 X No After this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifice funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Yes 2 No Other: 1 X Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

only one 29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, year occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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			For State Registrar	State of Marylar		artment of I tificate of L		Mental Hy	giene Reg. No. 20	11 38312
	Physicia		1. Decedent's Name (First, Middle, Las Ri	t) chard Leroy D	avidsor)		2. Date of De Month Novemb	ath	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give	·		4b. City, Town, o	r Location of Deat	•	4c. County of	Death
	Funeral		Union Hospita1 5. Social Security Number 6. Se		last birthday)		If Under 24 Hrs.		Ceci	9. Birthplace (State or Foreign
	Director		216-48-0554 1 Usual Residence of Decedent	X м 2 □ F 63	Yrs.	Months Days	Hours Min.	May 27	, 1948	Maryland
	and show dat	ĕ	10a. State 10b. County	10c. Ci	ty, Town or Loc	cation				10d. Inside City Limits
	Mary 28a-f)irec	Maryland Cecil	E	1k Mill	_				1 ☐ Yes 2 🔀 No
	with the 23a or ist be	Funeral Director	652 Elk Mills Roa	nd		10f. Zip Code 21920)		10g. Citizen of Wh	at Country? ed States
	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status	12. Was Decedent Ever in U.		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No- p Rican, etc.)	14. Race -	American Indian, White, etc.
920	s after ral", or Exami	ed by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	- 1	☐ Yes 2 🗓 No		,		White
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Baltimore, Maryland 21215-0036	be filed vental Hygred other ic event,	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Surname)	
ızla	should be fill n and Mental 7 is marked of raumatic eve	-	Robert Weldon Day 19a. Informant's Name/Relationship (Ty.)	· · · · · · · · · · · · · · · · · · ·	40h Mailia	- ^		S. Sco		7-0-1)
, Ma	1 and 2 should be of Health and Ment fitem 27 is marker rother traumatic e		Valerie L. Davids			- '			r, City or Town, Stat 3,E1k Mi	e, zip Code) 11s, MD 21920_
lore	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Toremation 3	Removal from State	Place of Dispos cemetery, crem	sition (Name of natory or other place	e) Nove	Date mber	20c. Location - C	
attu	permit, Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License	1 - 11	A. Ferri	s & Co., I	nc. 23,	2011 Cks Home	West	Chester, PA erals, P.A.
ñ	Der any		Miste High	Cusman		103 W.	Stockton	Street	, Elkton,	MD 21921
			23a. Part. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final	lications that caused the deat e cause on each line.	th. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)	a. Due to (or as a consequ	uence of):	NFARCTI	ON			Hours
	Examiner	<u>~</u>	Sequentially list conditions,	b. CORONARY		ERY DIS	ease			YEAKS
	ted d insit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	HYPERTE	,					YEARS
	sate be executed physician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequ	uence of):		-			
20	cate be physic the b	ledical		d. HYPERLI	PIDEM	4	-			YEARS
α ×	h certifi tending r use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta	incy al death 3 🗆	Ectopic pregnance	v		23d. Date	of delivery
. Box	ne deat the at ched fo	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of o		Other (specify)			Month	Day Year
7. Ö	s that the	by P	Part II. Other significant conditions co			, ,			_	ite to the cause of death?
VITAI Records,	equire:		HON INSALIN C	EPENDANT DI	ABETE	MELLIT	sus	1 🗆 '		Probably 4 Unknown
eco	e has t	Completed						24a. Was a autop perfo	price price price dea	re autopsy findings available or to completion of cause of tth?
, O	ilan: The strifficate ctor, pa		25. Was case referred to medical examiner?			26. Pla	ace of Death (Chec	1 🗌 Yes	2 No 1	Yes 2 No
=	Physic this ce	욘	1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☑ 28a. Date of injury	ER/Outpatient		4 ☐ Nursing H		lence 6 Other (Specify)
	ath. r: After	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injury work M 1 □	γ aτ ? Yes 2 □ No	28d. Describe h	ow injury occurred	
DIVISION OF	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tow		or Rural Route Number,
ם	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physi (Check 2 Medical Examin	cian: To the best of my knowl	ledge, death o	ccured at the time,	date and place, a	nd due to the cau	use(s) and manner a	is stated. the cause(s) and manner stated.
	o the l		only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of my	knowledge, de	eath occurred at the	time, date and pla	ce, and due to the	e cause(s) and manne 29d. Date signed (A	er as stated.
			1 40 MO			DOOH		- 1		x 23,2011
			30. Name and address of person who co				4 -			
			DAVID GAR-EL 301	1-306 NORTH	STREET	SHITE ?	"3 ELW1	UN MA	EN LIBERTA	21921
	Stat Registra	~	B1. Date filed (Month, Day, Year)	1-306 NORTH 32. Rigistrar's Signat	ture _		"3 ELK	TOW MAI	ey Lywo	31921

30

RICHARD DAVIDSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **JAMES** ROGER DAWKINS November 19 2011 Pa 2:20 рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Elkton Cecil Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours March 29 Maryland Director 212-98-8549 46 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **RD 13** #300 Hollingsworth Manor 21921 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 K Married Maryland 21215-0036 If Yes, Give Year or Dates Yes 2 No White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Security Officer State of Delaware Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roger Levi Dawkins Janice Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie A. Dawkins (wife) 13 #300 Hollingsworth Manor Elkton, MD. 21921 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Kent Cremation Services 11/21/11 4 ☐ Donation 5 ☐ Other (Specify) Smyrna, DE. 21. Si para f Funeral rvice licens 22. Name and Address of Facility Galena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 2 M00510 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease of condition Onset and Death Physician. disease covition resulting in eath) Medical Due to (or a: a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Day Pregnant at time of death 2 No Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 X No 2 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No မ 24 hours after deaun. **e Funeral Director:** After this colleted filled in by the funeral director 1 Inpatient 2 KER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one nd title of certifier 29b. Signature 29c. License number D0062828 30. Name and address of p pleted cause of death (Item 23a) (Type, Print) 2192 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011 383

		1- For State Registrar	Certific	cate of Dea	th	Re	g. No.	1 0001
Physic		1. Decedent's Name (First, Middle, L	.ast)			Date of Death Month	Day Year	3. Time of Death
" - dical Exam	iner	JONATHON	DECKMAN			November	25, 2011	2014 hrs
		4a. Facility Name (if not institution, 6204 Lawyers Hill Road		Elkri	Town, or Location of Deadle	atn	4c. County of Death Howard	1
Funeral		-	Sex 7. Age (In yrs. last b		der 1 Year If Under 24h	rs. 8. Date of Birtl	h(MM/DD/YYYY) 9. Bir	thplace (State or
Director			✓M 2□F	Yrs. Mon		lin. 11-35	Foreig	
		Usual Residence of Decedent	W W Z F	/) ris.		11 .30	1	, (()
any		10a. State 10b. County	10c. City, Tow	vn or Location				10d. Inside City Limits
nd show	'n	MD ANNEA	RUNDEL	SEVER	2N			1 Yes 2 No
ne Maryland or 28a-f show fled at once.	Director	10e. Street and Number			ip Code	10	g. Citizen of What Cou	ntry?
eath with the Maryland items 23a or 28a-f sho ust be notified at once		1449 GEORGIA	AVE.		21144		0.5.	4.
h with	era	11. Marital Status	12. Was Decedent Ever in U.S.		lent of Hispanic Origin? (cify Cuban, Mexican, Pue		14. Race - Amer White, etc.	ican Indian, Black,
	Funeral	1 Never Married 2 Married	1 Yes 2 No		_/	,	/ 0/	1
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she as Examiner must be notified at once	by	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ced If Yes, Give Yeer or Dates:		2 No specify:	of work done	Specify: (16b, Kind of Business/	111E
2 hours afte "natural" Examine	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		orking life. DO NOT use r		Tob. Tana of Basinossi	industry .
D36 thin 7 ne.	nple	12	1,1	ARFHOUS	EASSISTAN-	-	FIRER ON	TICS CO.
15-0036 filed within 72 I Hygiene. Ad other than "	Co	17. Father's Name (First, Middle, La	ist)		18.Mother's Na	me (First, Middle, M	aiden Surname)	1.02
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", e event, the Medical Examiner	Be		ECKMAN		Chara		COLE	
D 2. should and M.	J.	19a. Informant's Name/Relationship			SS (Street and Number of	,	•	e, Zip Code)
10re, MD 21215 ages I and 2 should be file nt of Health and Mental H: I: If item 27 is marked other traumatic event, i		Charnel Party 20a. Method of Disposition	EMORE, HOTHER 1	e of Disposition (Na	DRRIA AVE	Date Date	20c. Location - City or	Town State
Baltimore permit. Pages 1 a Department of He Important: If it		1 Burial 2 Cremation		atory or other place				
t. Pag trment rtant:		4 Donation 5 Other Spec		RUNDER	DEMOTORY O	トノーハ	OVENTO	N,MD,
Baltimore permit. Pages 1 Department of F Important: If injury or other		A Distribution Services	Modern	0/.01	Made San Et al	LOGNERT 102 And	YFUNEAA	
Physician	_		mplications that caused the death. Do n	not enter the mode	of dying, such as cardiac	or respiratory arre		Approximate Interval
/Medical	j	failure. List only one cause on Immediate Cause (Final disease	each line. a. Multiple Injuries					Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consequence of):					
	_	Sequentially list conditions,	b	_				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of): c.					
d sit	xan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
760, icate be executed physician and the burial - transit			d					
'60, ate be ex physician he burial	edical	UNPENDED	AMENDED					
876 iificate ng phy us the	Σ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy	ÿ 2	3 Ectopic preg	nancy	23d. Date of delivery Month	V Day Year
Box 687 death certifine the attending ped for use as t	icia	past 12 months? 1 Yes 2 No 9 Unkno	4 Pregnant et time of death	5 Other (Sp	_			
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ires that the signed by I be detached	by	Part II, Other significant condition	s contributing to death but not resulti	ing in the underlyin	g cause given in Part I.		2 ✓ No 3 Prob	
rds, I requires been sig						24a. Was ar		topsy findings available
COFC law re has be 2 sho	Completed					autops perform	y prior to d	completion of cause of
ital Reco ician: The law certificate has rector, page 2 s	ဒ္					1 ✓ Yes 2	No 1 ✓ Ye	es 2 No
ician: certification	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ER/0	Outpatient 3	26.Place of Death (Chec		Residence 6 🗸 Other	
of Vil ing Physic After this funeral dire	၉	1 Yes 2 No	28a Date of Injury 28b	o. Time of Injury	DOA Outel 4 Nurs 28c. Injury at Work?		ow injury occurred	- Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Certification:	1 Natural 5 Pending	FOUND: Day, Yeer) FO	OUND:	1 Yes 2 ✓ No		uto fixed object co	ollision
ision r Attent er death rrector:	ica	2 ✓ Accident Investig 3 Suicide 6 Could n	28e Place of Injury - At home	09 hrs farm, street, factor	y, office building, etc.	28f. Location (St	reet and Number or Ru	ral Route Number, City
Divising pital or At ours after deral Direct filled in by	erti	Suicide 6 Could n 4 Homicide				or Town, Sta 6204 Lawyer H	^{ate)} ill Road, Elkridge, M	D
Hosp 24 ho Fune stely fi		29a. Certifier (Check only 1 Certifying Phys	ician: To the best of my knowledge, de	leath occurred at th	e time, date and place, a	nd due to the cause	(s) and manner as state	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	2	ner: On the basis of examination and/or and manner stated.	r investigation, in m	y opinion, death occurred	d at the time, date a	nd place, and due to the	e cause(s)
	Σ	29b. Signature and title of certifier		29	9c. License number		29d. Date signed (Moi	
		War.			O.C.M.E.		November 26, 20)11
			o completed cause of death (Item 23a) Medical Examiner 900 W. I	•	et Baltimore MD 1	21223		
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	2 Aminore offe	To animore, ND 2	- 1220		
Regis		DEC 0 1	2019 General B.	. park	<i>!!</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38315 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26 2011 NOVEMBER PATRICIA ANN DRURY 11:30 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12334 Galena Rd. Massey Kent If Under 1 Year Social Security Number . Age (In vrs. last birthday If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Davs Hours Min OCT. 31 214-34-5284 Director 76 1935 Delaware Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No Kent Massev 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12334 Galena Rd. 21650 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 □ Divorced Specify Year or Dates. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James B. Wright Anna Mae Hunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Drury (daughter) P.O. Box 1 Galena, MD. 21635 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Crumpton Cemetery 12/1/11 Crumpton, MD. 21. Signature on type of Service 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 M00510 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate ck, or hea Interval Between Immediate Cause disease or condition resulting in death) Onset and Death (Final Physician/ d Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No 5 Other (specify) Month Day Year 1 Yes 24 9 Unknown is been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2. N 2 No Yes _ Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ည 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death le Funeral Director: A pleted filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

within 2 To the F

(Check

only one) 29b. Signature and title of certifi

W. Bruce Obenshain,

th, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

251

DHMH 17 Rev 7/2009

De

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00035779

Cecilton, MD.

November 28, 2011

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Bohemia Ave.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 38316 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:20AM Doretha C. Edwards ber 17 2011 NOVEM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince Georges Birthplace (State or Foreign Country)
 VA Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday, Months Day, Year) 1 22,1926 Director 231-34-8517 85 March Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director or 28a-f MD PG 1 XYes 2 No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 14803 Dolphin Way 20721 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner ģ 1 Never Married 2 Married ☐ Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 Yes, 1 ☐ Yes 2 X No Specify "natural", 3 Widowed 4 X Divorced Completed Black Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Food Service Worker permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDWARDS ၉ Jordan Moore Edith Cosby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14803 Dolphin Way
Bowie MD 20721 19a. Informant's Name/Relationship (Type, Print) Ronald Edwards/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/28/11 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Þark Landover, MD 21. Signatura of Funeral Service Lices 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 of t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ onto disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Grantiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Medical certificate be Box 68760 IF FEMALES Physician/ 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Month Year 4 Pregnant 9 Unknown Day Pregnant at time of death Other (specify) ed by the a detached 1 9 Unknown Division of Vital Records, P.O. cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has t completed filled in by the funeral director, page 2 s. autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deg 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation in manufacture. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD53718 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Goodhacic Rd., Lanham, MD. 20706 Thomas 10 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12, 2011 Felipa Ferrufino November 6:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Genesis Eldercare-Woodside Center Silver Spring . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 216-51-2307 Director 1 M 2 X F 88 May 26, 1923 El Salvador Usual Residence of Decedent show at 10c. City, Town or Location the Maryland 10d. Inside City Limits Director r 28a-f st notified a 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 10775 Lester Street 20902 El Salvador death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 🖾 Yes 2 □ No Specify: Salvadorean White If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed I Hygiene. other than "nature ent, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Homemaker Own Home of Health and Mental Hygie if item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Bartolome Ferrufino Paula Bonilla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is or other train Johanna Aragon/Grandchild 10751 Wayridge Drive, Montgomery Village, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 19 Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 2011 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Gastroesophageal Junction Tumor disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year Pregnant at time of death signed by the a d be detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Metastatic Carcinoma of Peritoneum and Colon 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 A No the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2**X** No မ 1 Yes 4 🖺 Nursing Home 5 🗌 Residence 6 🗆 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work?
1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

within 2

31. Date filed (Month, Day 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one

29b. Signature and title of certifier

E. DeVaughn Belton, MD 1629 Columbia Road, NW, #334, Washington, DC 20009 32. Degistrar's Signature

29c. License number

MD 25586

29d. Date signed (Month, Day, Year)

November 14, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011 38318

		1- For State Registrar	Certificate	of Death		. Re	eg. No.	1 0001
Physic Medical Exam		*				2. Date of Dea Month November	Day Year r 17, 2011	3. Time of Death 0609 hrs
		4a. Facility Name (if not institution, give street and number) 17712 Queen Elizabeth Drive		4b. City, Town, o	or Location of Deat	h	4c. County of Death Montgomery	
Funeral Director		219-68-4240 _{1×M 2} F	In yrs. last birthday) 53		ear If Under 24Hr ays Hours Mir	-	Foreig	hplace (State or n Maryland untry)
any		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Loc	cation				10d. Inside City Limits
Maryland 28a-f show 1 at once.	tor	MD Montgomery	Rock	ville				1 X Yes 2 No
eath with the Maryland items 23a or 28a-f sho ust be notified at once	al Director	10e. Street and Number 1010 Neal Drive	T	10f. Zip Code 208			Og. Citizen of What Coun United Sta	tes
fter d	y Funeral	3 Widowed 4 Divorced If Yes, Give Yeer	No H	If Yes, specify Cuban, Mexican, Puerto Ricán, etc.)			- 14. Race - Americ White, etc. Whi Specify:	
hours a natura	ed by	Lor Dates: 15. Decedent's Education (Specify only highest grade complete the complete that the complete the complete that the complete tha	eted) 16a. Deced	lent's Usual Occup	ation (Give kind of e. DO NOT use ret		16b. Kind of Business/Ir	ndustry
21215-0036 uld be filed within 72 hours a Mental Hygiene. marked other than "natural c event, the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 0		penter			Home Impr	ovement
215- be filed ntal Hyg riked ott	Be C	17. Father's Name (First, Middle, Last) George J. Fuchs			18.Mother's Nam Helen		th Peters	
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Bygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	To	19a. Informant's Name/Relationship (Type, Print) Mary C. Howard / Wife	101	0 Neal D	rive, Roo	kville,		20850
Baltimore, Dermit. Pages I an Department of Hea Important: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other Specify:	20b. Place of Disp crematory or Metropo			Date 1/22/11	20c. Location - City or Alexandri	
Balti permit. Departu Import	J	21. Strington of Mineral Service Incensee		. Name and Addres	110		Barber Fun	
Physician		23a. Part I. Enter the discase, or complications that caused the failure. List only one cause on each line.	e death. Do not enter	r the mode of dying	g, such as cardiac	IV CONSV1 or respiratory arre	11e, Maryla est, shock, or heart	nd 20882 Approximate Interval Between Onset and
/Medical examiner		Immediate Cause (Final disease or condition resulting in death) aAtheroscler Due to (or as a consequence)		iovascula	ar Diseas	e		Death
		Sequentially list conditions, b						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated						
uted nd ransit	- 1	events resulting in death) Last Due to (or as a consequence of the co	ience of):					
0, be exec sician al nurial - t	Medical	■ AMENDED ■ AMENDED 23a,	pt.II,27, ₁	per me,g	922 12-2-	11 sm		
18760, rufficate be ing physicias the buria		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 Live birth	, ,	Fetal death 3	Ectopic pregna	ancy	23d. Date of delivery Month Di	ay Year
Box 68's death certificate attending and for use as 1	Physician	1 Yes 2 No 9 Unknown 9 Unknown	e of death 5 (Other (Specify)				
P.O. Be so that the de gned by the		Part II. Other significant conditions contributing to death but	ut not resulting in the	underlying cause	given in Part I.	23e. Did to	bacco use contribute to the	ne cause of death?
is, P.(quires that en signed uld be deta	ted by	Cocaine Use				1 Yes	2 No 3 Proba	bly 4 Unknown ppsy findings available
e law re e has be	Completed					autops perfor	sy prior to co med? death?	mpletion of cause of
tal Recian: The certificate ector, page	es l	25. Was case referred to medical		26.Plac	e of Death (Check	1 Yes 2 only one)	2 No 1 Yes	2 No
f Vita Physici er this c	TO B	examiner? 1 Ves 2 No 27. Manner of Death Plospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatier	tad			Residence 6 🗸 Other:	Scene
on of ending Pl ath. or: After he funera	ţion	1 X Natural 5 Pending (Month, Day, Year)	28b. Time of	′′′	ury at Work? Yes 2 No	28a. Describe n	ow injury occurred	
Division of Vital Records, Hospital or Attending Physician: The law require 24 hours after death. Funeral Director: After this certificate has been si rectly filled in by the funeral director, page 2 should b	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	- At home, farm, str	eet, factory, office	building, etc.	28f. Location (S or Town, St	treet and Number or Rura ate)	al Route Number, City
4 4 4 4	Medical Co	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examin.						
To To To com	¥	and manner stated. 29b. Signature and title of certifier	-	29c. Licen			29d. Date signed (Mont	
		high.		0.0	.M.E.		November 18, 20	11
3.1		 Name and address of person who completed cause of deat Ling Li, MD Assistant Medical Examiner 		ore Street, Bal	timore, MD 21	223		
St Regist	ate rar	31. Date filed (Month, Day, Year) 2 2011 32. Registrar's S	Mi A.	arkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Morris Sylvester Ferguson Month 11 12:06 PM 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 7519 Buchanan Street, Apt.#335 Hyattsville Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 1 □xM 2 □ F Days Hours 09 06 1 1954 579-72-4245 DC Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Prince George's Hyattsville 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7519 Buchanan Street, Apt.#335 20784 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Yes 2 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes Give Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Computer Technician Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary S. Reeder Cornelus M. Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shutina Ferguson/Daughter 1732 Addison Road South, District Heights, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Suitland, MD 4 Donation 5 Other (Specify) 11/18/2011 National Harmony Signature of Funeral Service Lice 22. Name and Address of Facility Pope Funerals Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747 101081 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Cardiopulmonary Arrest Onset and Death disease or condition resulting in death) Due to (or as a consequence of) Pancreatic Cancer Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Physician/ Medical Examiner Examiner Hospital or Attending Physician: The law requires that the death certificate be executed trar and burial ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

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Examiner

Funeral

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Maryland 21215-0036

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29a. Certifier

			1 Pes 2 No 3 Probably 4 Unknow
			24a. Was an autopsy performed? 1 Yes 2 XNo
5. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	26. Place of Death (Chec	ome 5 X Residence 6 □ Other (Specify)
7. Manner of Death 1		28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
4 Homicide determine		tory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Irving Street

29b. Signature and title of certifi

NW, Washington, 32. Regis

DC , Suite#315, 20010

29d. Date signed (Month, Day, Year)

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38320 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2011 Nov 18, 6:57PM ^M <u>Fazenbaker</u> Medical Anna Lee 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany <u>WMHS-RMC</u> Cumberland Birthplace (State or Foreign Country)
 MD Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🗔 Hours Min. Month, Day, 1955 **Director** 218-62-7009 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director notified 28a-f MD Allegany LaVale 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? r items 23a or ner must be r Funeral 9 Asbury Avenue, Lot 21 21502 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Specify: white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 own home homemaker Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Shirley Minke Andrew Metzner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Asbury Avenue, Lot 21 LaVale MD MD 21502 Ray Fazenbaker son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 1 Burial 2 Removal from State MD 4 Donation 5 Other (Specify) Cresaptown permit. 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ EPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ABCESS ON BACK Sequentially list conditions, if any, leading to immediate cause Enter Uncertaing Cause (Disease or iinjury Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires MORBID OBESTTY cate has been signated bage 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? Yes 2 XN 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 XNo 욘 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Number Fractions. To the basis of my stated and occurred at the time, date and due to the cause(s) and manner as etablic. (Check

State Registrar 29b. Signature and title of certifier

Grega C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donaldson M.D.

32. Re trar's sign

's Signature

DHMH 17 Rev 7/2009

The

29c. License number

42057

912 Seton Drive Cumberland, MD 21502

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Physician/ Ralph Eugene Fry November 2011 10:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Citizens Nursing & Rehab. Center Frederick Frederick 8. Date of Birth May 29, Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Mary land Director 219-07-8243 92 1 X M 2 □ F Usual Residence of Decedent 28a-f shov 10a. State 10b. County Ħ 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Frederick Frederick 1 Xyes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? must be 23a Funeral 2507 Coach House Way #2B 21702 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner 0 ģ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Year 53425 1946 Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant US Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lawrence C. Fry Marv Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Tyson (Sister) 2507 Coach House Way #3A, Frederick, MD 21702 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ┶ 5 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or 4 Donation 5 Other (Specify) Mt. Olivet Cemeterv 11/22/2011 Frederick, Maryland 21. Signature of Funeral Service Licensee Keeney & Basford P.A. Funeral Home MO1612 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Hypertension disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Degenerative Joint Disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last physician is the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as attending property for use as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed Dementia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X No Hospital or Attending Physician: The certificate death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 Residence 6 Other (Specify, thin 24 hours after death, the Funeral Director: After this mpletely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 deficiency in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) MD. D0054636 November 17, 2011 30. Name and address of ho completed cause of death (Item 23a) (Type, Print) Dr. Syed W. 700 Montclaire Avenue, Frederick, Maryland 21701 Haque 31. Date filed (Month, Day, Year)

Registrar

NOV 30

11-08510 Tyray Gilbert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2011	3	8	3	2	6
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		1- For State Ce.	rtificate of	Death		Reg.	No.	
Physici		Decedent's Name (First, Middle,Last)			2	Date of Death Month	ay Year	3. Time of Death
ু lical Exami		TYPAY DAVON GILBERT				November 1	2, 2011	1415 hrs
		TY RAY DAYON GILBER 7 4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or Locat	tion of Death		4c. County of De	eath
		100 Brown Street		Chestertown			Kent	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If I	Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9.	Birthplace (State or
Director			• •		lours Min.		Fo	reign
Director	L	212-02-1812 1XM 2 F	29 Yrs.			08.28.	1982	Country) MD
		Usual Residence of Decedent	T					10d. Inside City Limits
' any			, Town or Location					
nd show	5	MD TENT MI	llington)				1 Yes 2 X No
Maryland 28a-f show d at once.	헗	10e. Street and Number	3	10f. Zip Code		10g	. Citizen of What C	country?
ith the Maryland 23a or 28a-f sho notified at once	Director	110 PM 22 22 201		21651			USA	
7th t		11.8 Pfnlagroff Road 11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was	Decedent of Hispanic	c Origin? (Spe	cify Yes or No-	14. Race - An	nerican Indian, Black,
ath v	Funeral	1 V Never Married 2 Married Armed Forces?	If Ye	es, specify Cuban, Mex	xican, Puerto F	tican, etc.)	White, etc	l l
er de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2 X No spe	ecify:		Specify:	lack
s aft	ā	or Dates: 15. Decedent's Education (Specify only highest grade completed)		's Usual Occupation (C		ork done 1	6b. Kind of Busine	
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	ost of working life. DO				
36 hin 72 e. than	읦		FASTF	ood cour		i	meDonal	d
with with Mer the	통	17. Father's Name (First, Middle, Last)	(other's Name (First, Middle, Ma	•	
Hygh Hygh								
21215-(uld be filed v Mental Hygi marked oth	Be	MAURICE Gilbert	1401 11	Address (Street and	mela	Burris	Oit T Oi	Into Tin Codo)
MD 21215-0036 1 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f shoumatic event, the Medical Examiner must be notified at once	-	19a. Informant's Name/Relationship (Type, Print)						
ME d 2 s lth au 17 m 27 m 27		Yamela Coppee- Mother	111844	Algroff Rd (nillings	on mary	and 2165	or Town State
Ore, MD 21215-003 es I and 2 should be filed within of Health and Mental Hygiene. If iten 27 is marked other the ther traumatic event, the Med		20a. Method of Disposition 20b. 1 X Burial 2 Cremation 3 Removal from State	crematory or oth	tion (Name of cemeter ier place)	y,	Date	20c. Location - City	7 Of Town, State
Baltimore, MD 2121 oemit. Pages I and 2 should be fi Department of Health and Mental important: If item 27 is marked injury or other traumatic event,		4 Donation 5 Other Specify:	race land	hed malhadi	et 11.1	9.200	Chesteet	town md
Baltimo permit. Page Department of Important: injury or oth	- 1	21. Signature of Funeral Service Licensee	22. N	ame and Address of Fa	acility En	w Hrzz	Alley un	ERA EROICE
Balti permit. Departm Imports	- 1	The MARINE	100	Z forset Dri				
Physician	-	23a. Part I. Enter the lisease, or complications that caused the death	n. Do not enter th	e mode of dying, such	as cardiac or	respiratory arres	t, shoot or heart	Approximate Interval
/Medical		failure. List only one cause on each line.						Between Onset and Death
∈xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)			1.	1 5		
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. associated wi		ible ingest	TION OF	creami	ig agent	_
	흘	cause. Enter Underlying Cause	51 j.					
7	E	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conseq	of):					
uteđ nd ransir	Exa	d.						
760, icate be executed physician and the burial - transit	Medical	X UNPENDED AMENDED 23a-b, p	t.II,27,	28a-f,per	me,g92	7 5-2-12	2 sm	
760, icate be physici	P P	IF FEMALE: 23c. If yes, outcome of pre	anancy				23d. Date of deli	very
876 ifical ig ph		23b. Was decedent pregnant in the 1 Live birth		tal death 3 Ed	ctopic pregnar	су	Month	Day Year
Box 68: e death certifi the attending ed for use as	ician/	past 12 months?	L No.	ner (Specify)				
BO; e deatl the att	Physi	1 Yes 2 No 9 Unknown 9 Unknown						
D. E t the d by the ached		Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause given	in Part I.	23e. Did tob	acco use contribute	to the cause of death?
P.O. es that the igned by be detacl	þ	Obesity, cocaine use				1 Yes	2 ✔ No 3 1	Probably 4 Unknown
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as it	Completed					24a. Was an		e autopsy findings available
SOFC law re has be	흷					autopsy perform		to completion of cause of h?
Rec The L	티					1 ✓ Yes 2		
tal Rec tisn: The certificate ector, page		25. Was case referred to medical			eath (Check o	nly one)		
Sion of Vital I Attending Physicisu: r death ector: After this certifi by the funeral director,	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA Othe	4 Nursing	Home 5 R	esidence 6 🗸 0	ther: Scene
n of \ding Phy. After tl funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Ir	njury 28c. Injury at 1	Work?	28d. Describe ho	w injury occurred	
ion (tendin eath. tor: A: the fur	<u>اة</u> ا	1 Natural 5 Rending	61.10-1	1 Yes	2 No		ingesti	on of cleaning
SiC Atte r dea ecto by th	Sal	2 X Accident Investigation 28e. Place of Injury - At	nome, farm, stree	et, factory, office building	ng, etc.	agent 28 Location (St	eet and Number o	Rural Route Number, City
Division of Vital Records, pital or Attending Physician: The law require are after death. reral Director: After this certificate has been s filled in by the funeral director, page 2 should be	Certification:	Suicide 6 Could not be determined (Specify)	i1/pena1					kers Dr.
<u> </u>		4 Homicide				Chestert		stated
To the How within 24 h To the Fur	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination	and/or investigat	ieu at the time, date ar ion, in my opinion, dea	ath occurred at	the time, date ar	nd place, and due t	to the cause(s)
withi To the comp	edi	and manner stated					29d. Date signed	
	Σ	29b. Signature and title of certifier		29c. License nur				
		N-1201-		O.C.M.E	i.		November 13	, ∠011
		30. Name and address of person who completed cause of death (Ite.	m 23a)					
	1	Donna M. Vincenti, MD Assistant Medical Exa		W. Baltimore Str	reet, Baltim	ore, MD 212	23	
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signa	ture/	4.1				
Regis	trar		B. ABC	effel				

Chonsay Green 11-08494

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** Chonscy Green 0004 hrs November 12, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7000 Arundel Mills Blvd. Anne Arundel 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours Min. 249-47-5337 1 X M 2 F 30 June 26, 1981 Country) SCUsual Residence of Decedent ıny Ob. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. Prince George's rmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ppartment of Health and Montal Hygiene.

ppartment of Health and Montal Hygiene in "natural", or items 23a or 28a-f sho lury or other than "natural", or items 23a or 28a-f sho lury or other thaumatic event, the Medical Examiner must be notified as once. Capitol Heights 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4209 Torque Street United States 11. Marital Status 12. Was Decedent Ever in U.S. or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 XNever Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Yes 2 If Yes, Give Year Examiner Divorced Yes 2 X No specify. Specify: Black <u>&</u> 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) narked other than event, the Medical Certified Groomer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Brinda Green 19a. Informant's Name/Relationship (Type, Print) ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brinda Green/ Mother Canyon Rock Court, #104, Raleigh, N.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 XCremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Riverdale Park Crematory/21/2011 Riverdale, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. ٤. 5538 Marlboro Pike, Forestville, MD 23a. Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause or /Medical Between Onset and a. Gunshot Wound of Head Immediate Cause (Final disease ≟xaminer Death or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical the attending physician and for use as the burial UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? 2 Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed After this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) examiner Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 Yes ER/Outpatient 3 DOA 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural FOUND: Subject shot d in by the f 5 Pending 1 Yes 2 ✔ No 2 _ Nov 11, 2011 2355 hrs Accident Investigation 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be determined or Town, State) 7000 Arundel Mills Blvd, Hanover, MD 4 Momicide (Specify) Parking Lot Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Allan O.C.M.E. November 12, 2011 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month D State Registrar

DHMH 17 Rev 1/2001 OCMF 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4 M George Godfrey Medical 5:30 tober 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehabilitation + Nursing Ci 5. Social Security Number 6. Sex 7. Ade (In val. last b. Salisburg Dicomico 7. Age (In yes. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours Min 1 XM 2 🗆 F (Month, Day, Yea -29-19 Country) Director 78 229-38-9359 VA 28a-f show 10a. State Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Wicomico Salisbury 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 703 Taft Court, Apt \mathbf{F} 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 ò 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 Yes 2 XNo Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Spedlack Completed 3 Widowed 4 Divorced Year or Dates George Godfre timore, Maryland 21215-00 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cement Layer <u>Donald Mason BrickCd</u> other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 John E. Finney Bertie R. Godfrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Granville Horsey/Son Bailey Lane, Salisbury, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State injury 4 ☐ Bonation 5 ☐ Other (Specify) Cemetery 11-5-2011 Parkslev, VA Wharton Signature f Funeral Service Licen 22. Name and Address of Facility 917 W. Isabella St Bennie Smith Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death fastatie Physician/ greunoma disease or condition resulting in death) -Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Examiner thus to the as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 L Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of after death.

Director: After this certificate has autopsy page performe death? Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 NO |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral L 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signaty nd title of ce and address of person who completed cause of death (Item 23a) (Type, Print).

No loss TSO sadulia, MD Dec Chric Ave. Salisbury, Md Niemolas 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month 9.45 P M Physician/ GOCHENOUR ALDINE 2011 MARION NOVMedical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON WILLIAMSPORT WILLIAMSPORT NURSING HOME 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Country) **Funeral** Days Hours Months 89 VIRGINIA 126/1922 230-30-7804 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. must be notified at Director FALLING WATERS 1 Yes 2 No BERKELEY WV 10g. Citizen of What Country? 10f. Zip Code 0 10e Street and Number 25419 USA 23a Funeral 105 WHIPPORWILL LANE ral", or items ? Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Yes 2 XNo þ 1 Never Married 2 Married WHITE 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 3 ₩ Widowed 4 Divorced "natural" Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Medical 15 Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) **AGRICULTURE** Elementary/Seconday (0-12) FARMER the 18. Mother's Name (First, Middle, Maiden Surname) Be 17 Father's Name (First, Middle, Last) EVA MAE MILLER 2 ERNEST MARION GOCHENOUR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 105 WHIPPORWILL LANE, FALLING WATERS, WV 25419 Department of Health a Important: If item 27 is any injury or other trainonce. BARBARA MOSES/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State MARTINSBURG, WV ROSEDALE CEMETERY 2011 4 Donation 5 Other (Specify) BROWN FUNERAL HOME, PO BOX 821, 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 327 W. KING ST., MARTINSBURG, WV 25402 RUB heldo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MUTE dianto Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Year Month Day in the past 12 months? Pregnant at time of death this certificate has been signed by the ral director, page 2 should be detached Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed autopsy page 2 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Other: Hospital 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes မှ 28d. Describe how injury occurred 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: injury 1 Natural 2 Accide 5 Pending 1 🗌 Yes 2 🗌 No after death.

Director: Af
d in by the fu Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Accider
3 Suicide Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 4 Homicide filled in by within 24 hours a

To the Funeral C

completed filled i Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Wertinging Engisteria. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Under the Dasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of who completed cause of death (Item 23a) (Type, Print)

State Registrar 580

Date filed (Month, Day, Year)

2. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38326 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ane rances 2:10 A M 2011 11 17 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Julia Manor Healthcare Jashington Magerstown Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year 1921 1 🗆 M 2 👿 F Months Maryland Feb. 90 **Director** 217-12-1028 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location **Funeral Director** notified 1 ¥ Yes 2 □ No Maryland Washington Hagerstown 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? ò ms 23a or must be n USA 11 W. Baltimore Street 21740 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Deceus. Armed Forces? Yes 2 No Examiner Black, White, etc. ŏ þ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 ☐ Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Clerk Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental F 127 is marked of it traumatic ever 2 Monroe E. Cock Laura Lee Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 1524 Sherman Avenue, Hagerstown, Md. 21740 <u>Joseph G. Hellane, III - Son</u> t: If item 2 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Hagerstown Crematory 11/18/2011 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Juneral Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Due to (or as a consec ARtery disease or condition Medical resulting in death) Examiner ia with Depression Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transit and that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical with Heart Failure Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L retained Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No the a 9 Unknown detached 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Hyperlipidemia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: Natural 28d. Describe how injury occurred Hospital or Attending 24 hours after death. work 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation the **Director**: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State Registrar (Check

29b. Signature and title of certifie

cause of death (Item 23a) (Type, Print)

3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Day, Year)

11/17/11

CANP-333 Mil Street, Hacerstown, MD 21740

11-08387 Robert Lee Hawkins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland / Department of Health and Mental Hygiene	е

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		1- For State Registrar		Cert	ificate of	Death			Reg. N	o.	11 0002	
Physici	an/	Decedent's Name (First, Middle,Last)						2. Date Mont	of Death		3. Time of Death	
edical Exami	iner	Robert Lee Hawkii	ns					Nove	h Day ember 8,	Year 2011	1607 hrs	
		4a. Facility Name (if not institution, give stree	et and number)		4	b. City, Town, o	r Location of	Death		4c. County of De	ath	
		Peninsula Regional Medical Co	enter			Salisbury			Wicomico			
Funeral		Social Security Number 6. Sex	7. Age ((In yrs. las	t birthday)	If Under 1 Ye		1.0	•	TEOR	Birthplace (State or eign	
Director		500-01-7608 1XM	2 F	92	Yrs.	Months Da	ys Hours	Min. 06	/29/19	919	Country) Missouri	
		Usual Residence of Decedent										
809		10a. State 10b. County	10	0c. City, T	own or Locatio	on					10d. Inside City Limits	
nd Show	F	MD Worcester		Pocor	noke Ci	ty					1 X Yes 2 No	
ne Maryland or 28a-f show fied at once.	ctc	10e. Street and Number				10f. Zip Code			10g. C	itizen of What C	ountry?	
he M	Director	9 Fourteenth Street	t			21851				USA		
with t		11. Marital Status 12.	Was Decedent Ev	ver in U.S.	13. Was	Decedent of H	ispanic Origi	n? (Specify Ye	s or No-	14. Race - Am	erican Indian, Black,	
eath item	Funeral	I I I I I I I I I I I I I I I I I I I	Armed Forces? Yes 2	7	If Ye	s, specify Cuba	n, Mexican, I	Puerto Rican, e	tc.)	White, etc		
her d		3 Widowed 4 Divorced If Yes	Giva Year 1939	-1963	1 1	Yes 2 v N	o specify:			Specify: Wh	ite	
urs ad tural	d by	15. Decedent's Education (Specify only hig	ites:					ind of work done	∋ 16b	. Kind of Busines		
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+))	during mo	st of working lif	e. DO NOT u	use retired)				
thin thin the tedical	du	12			Manaq	ement			M-	ilitary/	Government	
ed wi	S	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, M	liddle, Maide	en Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c eveot, the Medica	Be	Bryan Wesley Hawkins	3				Lora	Wright				
Ould a man	မှ	19a. Informant's Name/Relationship (Type, F	rint)		19b. Mailing	Address (Stre	et and Numb	er or Rural Rou	ite Number,	City or Town, Sta	ate, Zip Code)	
MD d 2 should and 27 is	Ė	Robert Hawkins/ Son			725 Ma	rquis <i>P</i>	lve.,	Salisbu	ry, M	21801		
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland into Health and Mental Hygene. it: If item 27 is marked other than "ustural", or items 23a or 28a-f sho other traumatic eveot, the Medical Examiner must be notified at once.		20a. Method of Disposition			ace of Dispositematory or other	ion (Name of co	emetery,	Date	200	c. Location - City	or Town, State	
ages ent of		1 Surial 2 Cremation 3 Re 4 Donation 5 Other Specify:	moval from State	Firs	st Bapt	. Cem	·	11/13/2	011 Po	ocomoke	City, MD	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Headin and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic eveet, the Medical Examiner must be notified at once.		21. Signature of Fu eral Service Licensee			22. Na	me and Addres	s of Facility	Hollows:	v Fune	eral Hom	P P A	
Dep De	1	21. Signature of Fureral Service Licensee 22. Name and Address of Facility Holloway Funeral Home, 107 Vine St., Pocomoke City, MD 21851										
Physician		23a. Part I. Enter the disease, or complication		e death. C							Approximate Interval	
(Medical		failure. List only one cause on each line Immediate Cause (Final disease a. Tors	e. o Injuries								Between Onset and Death	
≟xaminer			o (or as a consequ	uence of):							-	
		Sequentially list conditions, b										
	ē		o (or as a consequ	uence of):								
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ited d ansit	Ш	events resulting in death) Last Due to	/ (or do d dor.bodo	201100 01).								
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760, ficate be g physici the buri	eg	IF FEMALE: 23c. If yes, outcome of pregnancy									env	
187 tifica ng ph	2		Live birth	or progra		il death 3	Ectopic	pregnancy		3d. Date of deliv Month	Day Year	
Box 68 ceath certification attending ed for use as t	Physician	4	Pregnant at tim	ne of deat		er (Specify)			_			
BC dea	Ą	9										
P.O. Be	by P	Part II. Other significant conditions contr	ibuting to death b	ut not resi	ulting in the un	derlying cause	given in Part				to the cause of death?	
s, P.C nires that signed d be deta								[1]	Yes 2	VNo 3 P	robably 4 Unknown	
Cords, law requir has been s	Completed							2 4 a	. Was an autopsy		autopsy findings available o completion of cause of	
BCC ne lav te has	Ē							_	performed Yes 2	? death	?	
tal Rec		25. Was case referred to medical				26.Plac	e of Death (C	Check only one)			100 2 110	
Vita	Be	examiner? 1 ✓ Yes 2 No	al: 1 Inpatient	2 √ E	R/Outpatient		IOthan	Nursing Home		dence 6 Ott	ner;	
iof Vital Records, ing Physician: The law require After this certificate has been signeral director, page 2 should b	٦ ا	27. Manner of Death 28	8a. Date of Injury	2	8b. Time of Inj		ury at Work?			njury occurred		
Danie din	틻	Feliality	Nov 8, 2011	" 1	535 hrs	1	Yes 2 🗸 N	No Subjec	t driver in	auto auto c	ollision	
Division tal or Attendiins after death.	[g	2 Accident Investigation	28e. Place of Injury	y - At hom	e, farm, street,	factory, office	building, etc.	28f. Loc	ation (Street	and Number or	Rural Route Number, City	
Division pital or Attencours after death ceral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined	(Specify) Major	r Road	/ Highway			or T Winter (own, State) Quarter Ro	ad at US Rout	e 13, Pocomoke, MD	
		29a. Certifier (Check only 1 Certifying Physicien: To		-		ed at the time of	late and place		-			
To the Hos within 24 h To the Fuc completely	Medical	one) 2 Medical Examinar: On th	ne basis of examin	_								
So Wil	Š	29b. Signature and title of certifier	manner stated.			29c. Licen	se number		290	I. Date signed (A	Month, Day, Year)	
		Sille dans	1/MX			0.0	M.E.		No	vember 9, 2	011	
	-	30. Name and address of person who complete	ated cours of do-	th /Itam ?	39)							
			ant Medical E	,		Baltimore S	Street. Bal	ltimore, MD	21223			
E.T Of	ate	31. Date filed (Month, Day, Year)	32. Registrar's									
ા	rar	NOV 1 4 2011	Mesers	1	1. Som	Kel						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	partment of Health and Nertificate of Death		
	_		Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. 2. Date of Death	No. 3. Time of Death
	Physicia Medic		Judith Hatter		November	10, 2011 2:19 p ^M
3	Examin		4a. Facility Name (if not institution, give street and number) 13013 Matey Road	4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent 1 □ M 2X F 72 Yrs.		Jan. 25, 1	
	and show	ro	10a. State 10b. County 10c. City, Town or L	ocation	·	10d. Inside City Limits
	Mary 28a-f otifie	irec		Spring		1 ☐ Yes 2 ☒No
	ith the	ralD	10e. Street and Number 13013 Matey Road	10f. Zip Code 20906	10g.	Citizen of What Country? USA
	eath w	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Sp		14. Race - American Indian,
21215-0036	e filed within 72 hours after death with the Maryland trail Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 ∨ Yes 2 ★ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	(Rican, etc.)	Black, White, etc. Specify: White
5-0	2 hou "natu edical	plet	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work	sing 16b	b. Kind of Business/Industry
121	ithin 7 ene. r than	Completed		DO NOT use retired) ical Information S	pecialist	Federal Government
ğ	filed w al Hygi d other event,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maid	
ylar	should be file n and Mental H 7 is marked o raumatic eve	မ	Robert Andrew Hatter		e Veronica	
Maryland	2 shou h and 7 is m traum			ling Address (Street and Number or Rui 113 Brooke Knolls		
ē,	f Healt f Healt item 2 other		20a. Method of Disposition 20b. Place of Disp	position (Name of	Date 20c	. Location - City or Town, State
mo	Page nent o int: If			ematory or other place) 111 Cemetery Nov	01^{15} , Su	itland, MD
Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		21. Signatur of runer I ervice Licensee	22. Name and Address of Facility Francis J. Collins	Funeral H	lome Inc. ver Spring, MD 20901
м			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
-4	Ph_sician/		Immediate Cause (Final disease or condition Liver Failure			Onset and Death 1 month
in the	Medical Examiner		Due to (or as a consequence of):			
		ner	Sequentially list conditions, if any, leading to immediate b. Liver Metastasis Due to (or as a consequence of):			4 years
	outed nd ransit	Examine	Cause (Disease or injury that initiated events			5 years
	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
760	cate b physic s the b	edical	d			
(687	eath certificat attending ph	an/M	IF FEMALE: 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy		23d. Date of delivery
Вох	Attending Physician: The law requires that the death certificate be executed ir death. ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 Yes Sirth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown 9 Unknown	Other (specify)		Month Day Year
P.O.	nat the ed by t detacl		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
ls, l	uires t n sign uld be	ed by			1 ☐ Yes	2 🗷 No 3 🗌 Probably 4 🗎 Unknown
Sorc	aw require as been si 2 should	Completed		48	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Re	The la	Con			performed	death? No 1 Yes 2 No
ital	sician: certific irector	Be	25. Was case referred to medical examiner? 1 Yes 2 X No Hospital: 1 Incertiset 2 FR/Output	26. Place of Death (Chec		о Пои то то
of V	g Physer this ieral di	e: <u>1</u> 0	27. Manner of Death 28a. Date of provided the large of th	of 28c. Injury at	28d. Describe how in	e 6 Other (Specify) njury occurred
on	ending eath. or: Afte	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury	work? 1 ☐ Yes 2 ☐ No		
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	the Hospital or hin 24 hours atte the Funeral Dire		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place,	and due to the cause	s) and manner as stated.
	he Ho iin 24 I he Fu	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inviously one) 3 Certifying Nurse Practitioner: To the best of my knowledge	ge, death occurred at the time, date and p	lace, and due to the ca	ause(s) and manner as stated.
	To t		29b. Signature fold title of certifier Lotif B. Shurry MD	29c. License number		Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type	D21910	I NO	ovember 14, 2011
	20		Peter Sherer, MD 3921 Ferrara D	rive, Wheaton, MD	20906	
	Sta Registra	te ar	31. Date filed (Month, Day, Year) NOV 1 5 2011 32. Redistrar's Signature	parke		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 38329 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Year Month Heitz Betty Jane 3:30 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vindobona Frederick Nursin Heights 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth If Under 24 Hrs. **Funeral** 1 M 2 XE Min. (Month, Day, Year Months 319-01-6756 **Director** M13501 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits VA 1 Kes 2 No Purcell ville Loudon 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 200 South Maple Avenue 20132 USA 12. Was Decedent Ever in U.S. Armed Forces?,
1 ☐ Yes 2 M No if Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Travel Agant Ith and Mental Hygien 27 is marked other turaumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Frank Austin Kendall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr. Department of Health an Important: If item 27 is any injury or other trausonce. , VA 20132 2003. Maple Ave. Turcellu; le Pamela Loury 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11-9-2011 Metropolitan Cremotory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hall Purcellville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death)) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 - N the Hospital or Attending Physician: thin 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural injury 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one D0061410 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

FAR

9 2011

Box 68760

Records, P.O.

Division of Vital

801

32. Registrar's Signature

TOLL

HOUSE AVE

FREDERICK,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38330 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rosser November Hinsley, Jr 2015 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Spring Hospital Silver Montgomer Cross 7. Age (In yrs. last birthday) If Under 1 Year Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year) 254-04-1612 1 M 2 🗆 F Director 56 Georgia 28a-f show with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Montgomo Silver 1 Yes 2 No MD oring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 1709 20903 USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important! if item 27 is marked others any injury or others? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubas, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, and Mental Hygiene.
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Peneral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ obstructive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Ma33 24a Was an autopsy performed 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٥ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) ipletely filled in by the funeral 27. Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury V Natural Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) November 14, 2011 A006331

Registrar
DHMH 17 Rev 06-2011

State

1500 Forest Glen Road Silver Spring

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Physician/ 1:40 November Frank Roland Hayes, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerset Deal Island 9677 Melvin White Road 9. Birthplace (State or Foreign Country)
D.C. 8. Date of Birth
(Month, Day, Year)
Aug 6, 1940 If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 🕱 M 2 🗆 F 579-54-2459 Aug **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State hours after death with the Maryland Director 1 ☐ Yes 2X No Deal Island Maryland | Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō er than "natural", or items 23a of the Medical Examiner must be Funeral USA 9677 Melvin White Road 21821 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No
If Yes, Give 1958-1964
Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced Black Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Seafood Industry Waterman 12th Be 18. Mother's Name (First, Middle, Maiden Surname) filed 17. Father's Name (First, Middle, Last) ပ Frank Hayes Lillian Butler permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic to injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 431 Jefferson Street, Salisbury, Maryland 21802 19a. Informant's Name/Relationship (Type, Print) Frank R. Hayes, Jr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 11/08/2011 Salisbury, Maryland Salisbury Crematory 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Service Licenses 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hronic Immediate Cause (Final en Fm ir ian/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events burial-transi Due to (or as a consequence of): resulting in death) Last ng physician a as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse (23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death Month Day Year in the past 12 months? for Pregnant at time of death Yes 2 No Unknown detached 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfori 1 🗌 Yes Yes 26. Place of Death (Check only one 25. Was case referred to medica filled in by the funeral director, Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) ျပ 28b. Time of 28d. Describe how injury occurred 27. Marmer of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: injury 5 Pending Natura 1 ☐ Yes 2 ☐ No M Investigation
6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

Signature and title of g

2. Registrar's Sig

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38332 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day HOBSON Medical 2011 0035 Nov. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel PG ocial Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Days 577-56-1328 1 M 2 XF Hours **Director** 70 06-22-1941 Pennsylvania Usual Residence of Decedent 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD PG Upper Marlboro 1 X Yes 2 □ No 10e. Street and Number items 23a or 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 108 Joyceton Way 20774 USA 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?.

1 Yes 2 No Black, White, etc. ō 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black "natural" 3 Divorced 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygier Important: If item 27 is marked other to any Injury or other traumatic event, the once. and Mental Hygier Is marked other t 12 Security Guard Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Hobson Lucretia Green 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 108 Joyceton Way Upper Marlboro, MD 20774 Sharon A. Williams/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crem. 11-16-2011 Riverdale, MD 21. Signature of Funeral & 22. Name and Address of Facility Murray Funeral Home HOOM 1722 North Capitol St. NW Washington DC 20002 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Interval Between Immediate Cause (Final disease or condition 6 months Physician/ Cancer of Lung with metastases Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burialby Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 X No Pregnant at time of death Month 1 Yes 2 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Chronic Obstructive Pulmonary Disease 1 🏋 Yes 2 □ No 3 □ Probably 4 □ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available autopsy performed?
Yes 2 X No prior to completion of cause of death? 1 Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2X No Certificate: To 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1X Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi-29c. License number 29d. Date signed (Month, Day, Year) D24721 11-11-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed A. Sadup 16333 Laurel Bowie Rd. #208 Laurel, MD 20708 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ Donzell Hardy Medical acility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Comice Regional Mediens If Unde 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Country) 220-76-5126 51 Director 1 🗆 M 2 🕱 F Sept 14, 1960 MD 28a-f show 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State Director Yes 2 ☐ No Salisbury Wicomico MD 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral USA 21801 1012 Fairground Drive, Apt. #8 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No 9 þ 1 Never Married 2 Married Africanfiled within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced American the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) n/a n/a 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d Mental ⊦ marked of Doris M. Miles Page 1 and 2 should be Professor Hardy f Health and Nitem 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1115 E. Church St., Salisbury, MD 21804 Vincent Hardy/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State Crematory of Delmarva 11/07/2011 4 Donation 5 Other (Specify) Delmar, DE . Signatu - Tuneral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEVERE Physician/ disease or condition resulting in death) Medical **Examiner** sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No ģ Month To the Hospital or Attending Physician: The law requires that the death Dav Year 5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 2 should be 1 Yes 2 No 3 Probably Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 performed 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certificate: 28c. Injury at injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title D68552 s of person who completed cause of death (Item 23a) (Type, Print) SADIA, LOOF CARROLL STREET, SALISBURY, MD 21801

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month,

Day, Year)

NUV

Registrar's Signatu

State Registrar

31. Date filed (Month, Day Year)

DHMH 17 Rev 1/2001

Bolevard Smithborn, Mayland

30./Name and address of person who completed cause of death (Item 23a) (Type, Print)

229() Ja 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38335 for State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ Madelyn Loretta Harp 22.45M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 98 Mary land 213-24-9150 **Director** Usual Residence of Decedent items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2 ☐xNo Frederick Myers ville Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21773 U.S.A 10532 Highland School Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Paul Kline Sr. Etta Mae Kuhn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 10563 Highland School Rd. Myersville, Md. 21773 Patricia Frushour (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion United 20c. Location - City or Town, State 20a. Method of Disposition Date 25, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. Department o Important: If any injury or Myers ville, Md. 2011 12525 Bradbury Ave. 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ estive disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? Day Year Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ completed filled in by the funeral director, page 2 should be 2. No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 25. Was case referred to medical 26. Place of Death (Check only one) Be 2/ No Other: 1 Tyes မ 1 Inpatient 2, ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending work Accident 1 🗌 Yes 2 🗌 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, DO 054 Name and address of person who completed cause of death (Item 23a) (Type, Print) Jefterson 22911 ha 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Vear Frank Joseph Hoyman 2011 08:154 9 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frostburg Allegany 204 West Main Street Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 M 2 □ F Months Min. 10-28-1933 Pennsylvania 214-34-1471 78 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Allegany Frostburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21532 U.S.A. 204 West Main Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glass Manufacturing Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rebecca Hoyman Lewis Hoyman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45 Frost Village Frostburg, MD 21532 Debbie Porter daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 11-22-2011 Frostburg Mem Park Frostburg, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, P.A. MO23117 Sower 60 W. Main Street Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due (or as a nsequence of): Due to for as a consciouence offi Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown

Physician /Medical Examiner

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aftending physician for use as the burial

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Division of Vital Records,

Physician: The law

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Certification: To

Medical

Physician

Examiner

Funeral

Director

28a-f show

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "hadical Examiliar must be rediffied at

72 hours after

and 2 should be filed within lealth and Mental Hygiene. m 27 is marked other than

Health tem 27 i

permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Funeral

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Completed

Be

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Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 2 No

31. Date filed (Month, Day,

Yearl.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobaci	co use con	indute to t	ne cau	se or deathr
1 ☐ Yes	2 🗌 No	3□ Prol	bably	4 Unknown
24a. Was an autopsy performed	24b.	Were auto prior to co death? 1 Yes		dings available on of cause of

performed? 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner?

- 1	L	20. Flace of Death (Check this the)	
	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	t 3 DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify)	
ior	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		

27. Mann Death 5 Pending investigat 2 Accident 6 ☐ Could not be 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

ause of death (Item 23a) (Type, Print) 30_ Name and address of person who complete 925B

State Registrar Registra's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 14, 2011 5:55 PM MAURICE LINWOOD JACKSON 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HARFORD MEMORIAL HOSPITAL HARFORD HAVRE DE GRACE 8. Date of Birth (Month, Day, Year JAN 25, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1**X** M 2□ F 76 Yrs. 1935 MARYLÁND 215-32-1298 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No MARYLAND HARFORD **ABINGDON** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20 BOX HILL S. PARKWAY, APT 117 21009 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1957. 1 Never Married 2 Married 1 □Yes 2X No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) HORTICULTURE THERAPY ASSITANT VA HOSPTIAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RICHARD JACKSON ELIZABETH M. WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20 BOX HILL S. PARKWAY, APT 117, ABINGDON, MD 21009 BARBARA JACKSON (WIFE) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State BERKLEY CEMETERY 11/19/11 DARLINGTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 - 000 nan 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral

Director

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filed within 72 hours after

Pages 1 and 2 should be ' nent of Health and Mental

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Physician/Medical

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Completed

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Certification: To

Medical

23b. Was decedent pregnant in the past 12 months? 9 Unknown

25. Was case referred to medical examiner?

29b. Signature and title of frtifie

31. Date filed (Month, Day, Year)

1 ∏ Yes 2 🕅 No

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

4 Homicide

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner states

1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Hospital:

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOME

32. Regist/ar's Signature

State Registrar

12+1VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Johnson Tames 2011 1513 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Maryland Snock Trauma Baltimore Baltimore University If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Wash, 8. Date of Birth **Funeral** 1 **X** M 2 □ F 9-9-195 577-66-5704 60 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Germantown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a Completed by Funeral 13016 Vaden Terrace 20786 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: rr Yes, Give Year or Dates.1973-74 3 Widowed 4 X Divorced of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Medical Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ James W. Johnson Lucille Greene 19a. Informant's Name/Relationship (Type, Print) (Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10704 Nast Dr. Cheltenham MD. 20623 Bernardette Copeland 20a. Method of Disposition 20b. Place of Disposition (Name of em cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 s Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 11 - 22 - 11Cheltenham MD. 4 ☐ Donation 5 ☐ Other (Specify) Cheltenh<u>am Vet</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hunt Funeral Home Franco 908 Kennedy St. N.W. Wash, D.C. Hunt 20011 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ nraventricular disease or condition resulting in death) 19 Medical Due to (or as a consequence of): Examine 10 Arteriovenous Malformation Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami signed by the attending physician and deedetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
-Funeral Director: After this certificate has been signed by the attending physicis eted filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebral Aneurysm Hypertension, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No Hospital: ျှ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔦 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

UR 5

State Registrar KIM BOSWELL, MD, 22 S. Greene St 31. Date filed (Month, Day Year) 32. Registrary Signature NOV 1 6 2011 Services 32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Borwell, MO

Baltimore

29d. Date signed (Month. Day, Year)

11/7

11-08868							
Janet Johnson							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

anet Johnson		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.								
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Janet Marie Johnson				Date of Death Month November 2		3. Time of Death 1929 hrs		
		Facility Name (if not institution, give street and number) 1488 Mara Vista Court	4	4b. City, Town, or Locati Crofton	ion of Death		4c. County of De Anne Arund			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 212-96-0375 1 M 2 X F 45	rthday) Yrs.	Months Days He	ours Min		(MM/DD/YYYY) 9. For	Birthplace (State or eign CountryMaryland		
vfaryland 28a-f show any 1 at once.	or	Usual Residence of Decedent 10a. State	n or Locati		fton			10d. Inside City Limits 1 Yes 2 No		
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number		10f. Zip Code 211	1 /.	100	0g. Citizen of What Country? USA			
or items	Funeral	1488 Mara Vista Court 11. Marital Status 1	If Y	is Decedent of Hispanic es, specify Cuban, Mexi	cify Yes or No- ican, etc.)		nerican Indian, Black,			
21215-0036 Id be filed within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examiner.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	. Deceden	nt's Usual Occupation (Gost of working life, DO N	Give kind of wo		16b. Kind of Busines	ss/Industry		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last)			ther's Name (f		Federa	l Govt.		
2121; ould be fill marked ic event, is	To Be	Ernest T. Parsley 19a. Informant's Name/Relationship (Type, Print) 15	Lyda M. Phebus 19b. Mailing Address (Street and Number or Rural Route Number, City or					ate, Zip Code)		
, MD and 2 sho ealth and cm 27 is				Portobello			of, Maryla			
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and In Important: If item 27 is minjury or other traumatic.		1 Burial 2 X Cremation 3 Removal from State crema	Metr Metr	opolitan	Dec	1,2011	Alexandr:	ia. Virginia		
Balti permit. Departi Import		21. Signature of Funeral Service Ligensee 23a. 9 rt 1. Enter the disease, or complication, that caused the death. Do n	22. N Mo	lame end Address of Fa	illity	. P.A.	Funeral	Home		
Physician /Medical :xaminer	er	23a. 17 Ti. Enter the disease, or complication, that crossed the death. Do refailure. List only one cause on each lin. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate a. Dilated Cardiomy Due to (or as a consequence of): b. Due to (or as a consequence of):			as cardiac or r	espiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death		
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ox 687(ath certifica attending ph or use as the	Physician/M	23b. Was decedent pregnant in the past 12 months?	2 Fel	tal death 3 Eco	topic pregnand	Б у	23d. Date of delive Month	Pery Year Year		
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Division of Vital Records, tal or Attending Physician: The law requirers after death. 11 Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should	Completed					24a. Was ar autops perform 1 Yes 2	y prior t ned? death			
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/C	Outpatient	26.Place of De			Residence 6 🗸 Ot	har Saana		
ion of Vii tending Physic eath. tor: After this the funeral dire	tion: To	27. Manner of Death 1 Natural 5 Pending 2Ba. Date of Injury (Month, Day,Yaar)	. Time of Ir		Vork? 2		ow injury occurred	ner. Scene		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 2Be, Place of Injury - At home, (Specify)	farm, stree	et, factory, office building	g, etc. 2	8f. Location (St or Town, Sta		Rural Route Number, City		
To the Hot within 24 h To the Fun	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.		tion, in my opinion, deat	h occurred at t	he time, date a	nd place, and due to	the cause(s)		
	2	29b. Signature and title of certifier		29c. License num O.C.M.E.	ber		29d. Date signed (November 25,			
		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner		W. Baltimore Stre	et, Baltimo	re, MD 212				
St Regist	ate rar	31. Date filed (Mogth, Day, Year) 32. Registrar's Signature DEC 0 1 201	٦				CONE			
		Marie La La Caraca					COME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
Beverly Annette Knott 2. Date of Death 3. Time of Death Nortember Physician/ 1:15 Medical Facility Name (if not institution, give street and number)
Meritus Medical Center 4b. City. Town, or Location of Death 4c. County of Death Washington Examiner Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) 6-5-1965 1 □ M 2🗓 F 46 215-90-8323 Director Usual Residence of Decedent 28a-f show 10b. County Washington 10a. State MD aţ 10c. City Town or Location port 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 X No 10f. Zip Code 21795 ō 10e Street and Number 10g. Citizen of What Country? 23a 10817 Bower Ave U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or \$ 1 Never Married 2X Married white 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry residence and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 9th grade College (1-4 or 5+) the homemaker Be Father's Name (First, Middle, Last)
Adrian W. Strite 18. Mother's Name (First, Middle, Maiden Sumarne) Shirley M. Grove ပ 19a. Informant's Name/Relationship (Type, Print)
Cory Kline son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10817 Bower Ave Williamsport, MD 21795 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Smithsburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 2011 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22 Name and Address of Facility Thompson Funeral Home, 310 Clear Spring, MD 21722 P.O.BOX Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Straye disease or condition resulting in death) Head and eminal Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 DoNo 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ Mo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending Pl n 24 hours after death. e Funeral Director: After the pleted filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 062588 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW-2 Redical Campus Load 11116 MBAOUN JUDITH

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Mo

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KERN Month Wear I FLURENCE 1211 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7746 Frederick Road Hyattsville Prince George's Date of bill. (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 578-26-4001 1 M 2 M 1 Months Days Hours Min. Director 87 1924 Bellefontaine, Ohio October Usual Residence of Decedent show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Hyattsville 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? Funeral death with 7746 Frederick Road 20784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Completed by Black, White, etc. Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or 1 Never Married 2 Married 2 🔀 No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give White 3 Nidowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Clerk 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Franklin Butler Mary Mae Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie L. Billingsley - Daughter 7746 Frederick Road, Hyattsville, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cemetery 11/29/2011 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or pispiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ rleer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (prasia consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial-Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy for in the past 12 months? 4 Pregnant Other (specify) Month Day Year Pregnant at time of death Yes 2 No 1 Yes 2 Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate has page 2 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide work?
1 \(\sum \) Yes 2 \(\sum \) No injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fi Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) **Certifying Nurse Practioner** the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

and address of person

32. Registra

o completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:11P NOWHMBER PEG 20°1 ALLAN WESTLEY LEHMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth 6. Sex **Funeral** 1 X M 2 🗆 F Months Hours Min 05/01/2011 **Director** Pennsylvania 213-56-3624 60 Usual Residence of Decedent 10a. State 10b County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 2 X No Virginia Henry Bassett 10e Street and Number 10f. Zip Code 6 10g. Citizen of What Country? Funeral 23a 2912 Columbus Dr. 24055 U.S.A. items . Page 1 and 2 should be filed within 72 hours after death viment of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural", or items luny or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Bricklayer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Robert Wilson Lehman Hazel Geneva Frampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Lehman 2912 Columbus Dr. Bassett, Virginia 24055 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth cemetery, crematory or other place 1 Burial 2 Cremation 3 X Removal from State Science Care Colorado 12/2/2011 4
☐ Donation 5 ☐ Other (Specify) Aurora, Colorado 21. Sign of Funeral Service Vicensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Ph_sician/ disease or condition resulting in death) Medical pmmunity Acquired Phlummia Bacterial Examiner Esquantiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is interested as or iinjury Examine burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Be Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Day Year Pregnant at time of death the a signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Adde Levol Failure 1 Yes 2 No 3 Probably 4 X Unknown R Pneumothorax 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? 1 Yes 2 KNo certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ္ 1 X Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work?
1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

IW-5 State

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Registrar

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only one) 29b. Signature and title of certifie

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400 W 7th St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Frederick, MD 21701

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 58A M **Physician** 201 Helen Elizabeth LIGHTNER /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner llage avenwood Under 24 Hrs. (In vrs. last birthday) **Funeral** Months Yrs. 86 June 11 1925 Virginia Director 227-24-8318 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State show d other than "natural", or items 23a or 28a-f sho event, the Medical Evaniner must be notified at 1 ☐ Yes 2√2 No Director Maryland| Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16907 Harvinger Court by Funeral 21740 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 □Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify: White Specify 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory 12 Operator Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, II once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Elizabeth Musser Henry Adam Musser ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16138 Spade Road, Hagerstown, Maryland 21740 Jacqueline Blair 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 11/21/2011 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Marion, Virginia 4 Donation 5 Other (Specify) Carmel U.M. Ch. Cem. 21. Signature of Edneral Service Licenses 22. Name and Address of Facility Minnich Funeral Home Prolect S 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 54-cas Physician luni /Medical ue to (r as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending PhysIclan; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐ Yes 2∭(No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

Be Funeral Director; A pletely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide RCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

JW-3

State Registrar 368

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Hagerstown

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38344 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ 0235 2011 Yvonne Irene Lauricella Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Meritus Medical Center Hagerstown . Social Security Number 217-12-1190 7. Age (In yrs. last birthday) 91 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours June 3, 1920 Mary Land **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Maryland Washington County Hagerstown 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21742 U.S.A. 12914 Oak Hill Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Personal Residence Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Irene Barnes Nusbaum Chester Marshall Nusbaum ဂ္ permit. Page 1 and 2 should be Department of Health and Menl Important: If item 27 is marke any injury or other traumatic to 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15425 Wingerton Rd. Waynesboro, PA 17268 Richard W. Lauricella-son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 11-14-2011 Smithsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21 Sem How of Funeral Service License 331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final intestinai Physician/ (sthemis days disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ arres Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, rah. sw so 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Mo

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38345 State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ November 2011 9:17 Carlos Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 3210 Norbeck Road, Apt. 326 Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 212-43-1243 **Director** 1 🛛 M 2 🗆 F 95 June 21, 1916 Peru Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2XXNo Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or Items 23a 3210 Norbeck Road, Apt. 326 20906 USA death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 72 hours after 1 ☑ Yes 2 ☐ No Specify: Peruvian White If Yes Give 3 → Widowed 4 □ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Salesperson Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H is marked of Lazaro Lertora Rosa M. Lertora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Bural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau Sonia M. Castro/Daughter 3210 Norbeck Road, Silver Spring, MD 20906 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) X⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 19, Nov. Gate of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. MD 20901 500 University Blvd. W., Silver Spring. Part 1. Enter the disease, or complications that caused thi death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Anoxic Encephalopathy disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** 1 yr Heart Block Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Arteriosclerotic Heart Disease 20 vrs requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical P.O. Box 68760 IF FEMALE: JSe a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Year Dav Pregnant at time of death 4 ☐ Pregnam a 9 ☐ Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown Dementia Division of Vital Records, 24b. Were autopsy findings available 24a. Was an nis certificate has b I director, page 2 sl prior to completion of cause of death? autopsy performed? Hospital or Attending Physician: The Yes 2X No 1 Yes 2 No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🄀 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ funeral 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 7. Manner of Death 28d. Describe how injury occurred Certificate: After 1X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director. completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi D52382 November 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Danilo Molieri, MD 4701 Randolph Road, #216, Rockville, MD 20852 gistrar's Signature NOV 1 5 201 State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38346 **1 –** For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 27, 10:15A Physician/ 2011 GLORIA J LABOARD Medical 4c. County of Death FREDERICK 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 □ M 2🏋 F 69 Months 213-76-8133 Maryland Director 06/06/1942 Usual Residence of Decedent an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits the Maryland Director 1 🗆 Yes 2 😾 No MD Frederick Middletown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4604 Pinewood Trail 21769 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 Yes 2 XNo
If Yes, Give
Year or Dates. ò Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ▼No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be fill at of Health and Mental if item 27 is marked ည Elizabeth (unknown) traumatic Bracy LaBoard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Ann Bambrick / friend 2090 Old Farm Dr., Suite 1E, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State ò Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) <u>Smithsburg Crematory 11/28/2011 | Smithsburg, Maryland</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home MO1222 106 E. Church St., Frederick, MD 21701 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): physician and s the burial-trans that the death certificate be exect Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl I for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law in within 24 hours after death.

To the Funeral Director: After this certificate has E completed filled in by the funeral director, page 2 si autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending work? 1 \(\text{Yes} 1 Natural 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sic 0006 2223 bress of person who completed cause of death (Item 23a) (Type, Print) TDRIVE, PREDERICK, MJ 21202. BOLALUM MI PRAYEEN 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

De

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 38347 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 23 2011 STEVEN JOHN LEE 12:16 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 29 5th Ave. Earleville Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. (Month, Day, Year) an 4 1957 1 X M 2 □ F Pennsylvania Director 193-50-5726 Jan 4 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No MD Cecil Earleville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29 5th Ave. 21919 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ğ 1 X Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance/Dock hand 12 Marina Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Malcolm Lee Ruth Haines permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilton Head Island, SC. 29926 (brother) 16 Pineland Rd. J. Scott Lee Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Kent Cremation Services 11/24/11 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Galena Funeral Home of Stephen L 118 West Cross St. Galena, MD. 2 M00510 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or constition Ph_sician/ liver failer Medical resulting in d ath) **Examiner** years hosis Sequentially list conditions, Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit chronic that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months? Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2. No 2 1 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Materitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 00035779 November 23, 2011

DHMH 17 Rev 7/2009

State Registrar 25/

Bohemin Ace Cecilton, MD 21913

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Obenshain,

32. Registrar's Signature

nuce

31. Date filed (Month, Day, Year)

			For State Registrar	State of Marylan		artment of			Z U		3834
	Physicia Medi		1. Decedent's Name (First, Middle, Last) FRANK A. LOWE	•				2. Date of Deat Month Nov •	Day	Year 0 1 1	3. Time of Death 7:09P M
	Examir Funeral	ner	4a. Facility Name (if not institution, give structure) Upper Chesapeake 5. Social Security Number 6. Sex			4b. City, Town, Bel		8. Date of Birth	4c. County o	rfor	d ace (State or Foreign
l.	Director		216-38-3194 1 Nusual Residence of Decedent	M 2 □ F 70	Yrs.	Months Days	Hours Min.	(Month, Day, 4 / 7 / 1	Year) 9 4 1	MD Country	y)
	ne Marylan or 28a-f sh notified a	Director	10a. State MD Harfor		y, Town or Lo White			1.	0g. Citizen of Wi		d. Inside City Limits
	ath with the ms 23a community be	Funeral	1406 Old Pylesvi	lle Road 2. Was Decedent Ever in U.S	112.1		21132		1	USA	
9003	ould be filed within 72 hours after death with the Maryland ad Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 25a or 28a-f show marked other than "hadical Examiner must be notified at	þ	1 Never Married 2 🔀 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 No If Yes, Give 1 960 —	'	f Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto o Specify:	o Rican, etc.)		- Americar , White, etc Whi	c.
Baltimore, Maryland 21215-0036	within 72 ho giene. ner than "na er, the Medic	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Seconday (0-12)		(Give I	lent's Usual Occu kind of work done O NOT use retired ectrici	during most of world)	nost of working 16b. Kind of Busin			•
yland	ild be filed Mental Hy larked oth	To Be	17. Father's Name (First, Middle, Last) Frank A. Lowe,	Sr.			18. Mother's Nan Eliz	ne (First, Middle, M abeth L	laiden Surname). ee Wat!	kins	
, Man	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type Juanita Atwell		19b. Mailir 1406	ng Address (Street Old Py	and Number or Rui lesvill	ral Route Number, e Road,	City or Town, Sta	ate, Zip Cod ford	, MD211
imore	permit. Page 1 ar Department of He Important: If iter any injury or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cren	sition (Name of natory or other pla agle Cr			20c. Location - C Leola,	-	n, State
Balt	permit. Departi Import any inji		21. Signature of Funeral Service Liceptee 22. Name and Address of Facility Harkins Funeral Home, Inc.,								a, PA
	Physician Medical Examiner	er	23a. Part 1. Enter the disease, complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.	Due to (or as a consequ	ab (L uence of):	er the mode of dyi	ng, such as cardiac	or respiratory arres	st,	- In	Approximate nterval Between pnset and Death
092	iath certificate be executed attending physician and for use as the burial-transit	edical Examine	if any seeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ							
. Box 687	8 8 8	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	b. If yes, outcome of pregnal 1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	ıl death 3 🗌	Ectopic pregnar Other (specify)	псу		23d. Date Mont	of delivery	y Day Year
ds, P.O.	Physician, The law requires that the de this certificate has been signed by the ral director, page 2 should be detached	by	Part II Other significant conditions cont	ributing to death but not resi	ulting in the u	nderlying cause g	iven in Part I.		acco use contrib		cause of death?
Recor	nysician; The law re nis certificate has be I director, page 2 sh	Completed	25. Was case referred to medical					24a. Was ar autops perforn 1 Yes 2	y pri ned? de	ior to comp ath?	y findings available pletion of cause of
f Vita	Physiciar this certif	To B	examiner?	spital: 1 Appatient 2 28a. Date of injury	ER/Outpatier	Lot	4 ☐ Nursing H	ome 5 Reside			<u>.</u>
Division of Vital Records,	or Attending ifter death. Director: After in by the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	(Month, Day, Year) 28e. Place of Injury - At ho building, etc. (Specify,	injury me, farm, stre	M 1 [28d. Describe how 28f. Location (Str. City or Town,	eet and Number		'oute Number,
Ō	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After thi completed filled in by the funeral	Medical ((Check 2 Medical Examine only one) 3 Certifying Nurse I	an: To the best of my knowler: On the basis of examination Practioner: To the best of my	n and/or invest	igation, in my opin	ion, death occurred a	at the time, date and	d place, and due t	o the cause	e(s) and manner state
9	To t		29b. Signature and title of certifier 30. Name and address of person who com	ON Injeted cause of death (Item	23a) (Type P		se number 0633	&1	8d. Date signed (Month, Da	y, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar

Bel Air, MD

21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Fig. 1214/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registra 38349 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Charles Joseph Lucassen 04:56 M 2011 Nembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Washington Hagerstown 217 Security Number If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Month, Day, Ye. 1 🔀 M 2 🗆 F Months Days Hours 271-26-1250 82 Yrs **Director** Sept. Maryland Usual Residence of Decedent 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director must be notified 1 X Yes 2 No Maryland Washington Smithsburg ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral with 65 Byron Drive 21783 U.S.A. items death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 \(\text{No} \) No \(\frac{Arm}{1.95} \) 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Army 1951 1953 Black, White, etc. ö þ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. white Specify "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Book Binder Book Company 9 other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic Avent filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Lucassen Josephine Marie Schriver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie I. Lucassen (Wife) 65 Byron Drive Smithsburg, Maryland 21783 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Novembe 28, 2011 Holy Redeemer Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service 22. Name and Address of Facility MO1414 J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardia ar disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine executed Cause (Disease or iinjury that initiated events and -tran a consequence of resulting in death) Last burialattending physician for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Dav Year Pregnant at time of death ed by the a 9 Unknown P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Tonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page 2 certificate 1 Yes 2 No Yes 2 Z Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 🛮 No 1 Inpatient 2 ER/Outpatient 3 DOA ည this 28a. Date of injury (Month, Day, Year) hin 24 hours after death.

the Funeral Director; After thi

mpleted filled in by the funeral 27. Manner Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 🗌 No М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d, Date signed (Month, Day, Year)

7/2

State

Registrar

M

Dr. Vincent Cantone

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLAGE

egistrar's Signature

D50362

13424 Pennsylvania Ave. Hagerstown, Maryland 21742

November 27, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16. November 2011 3:15 Wayne Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 652 N. Mulberry St. Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 10/22/1924 1 M 2 □ F Hours Director <u> 201–16–6507</u> 87 Pennsylvania Usual Residence of Decedent shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 ☐ No MD Washington <u>Hagerstown</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 652 North Mulberry Street 21740 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify. Completed 3 Widowed 4 Divorced Specify: Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Transportation Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Danie1 Mumma Goldie Blanche Kelso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorine Lois Mumma / Spouse 652 North Mulberry Street, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 📕 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 11/19/2011 Hagerstown, Maryland Signature of Funeral Service Licen 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Wear Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin attending physician and for use as the burial-transit law requires that the death certificate be executed Cause (Disease or impury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Pregnant at time of death Day Yes 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy performed? Yes 2 No page Hospital or Attending Physician: The After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 41667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Michae

TW-LLET

Nelornack

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed

			State of Maryl	and / Dep	artment of H	Health and	Mental Hyg	iene		30	351		
Physicia		Registrar 1. Decedent's Name (First, Middle, Last)	stello Mar	nchester	rtificate of E	<i>Jeann</i>	2. Date of Deat			3. Time of 0 3:05			
Medic Examin		4a. Facility Name (If not institution, give stream Arden Courts Assis			4b. City, Town, or Silver	Location of Death	1		y of Death	7			
Funeral Director		5. Social Security Number 264-03-1923 Usual Residence of Decedent	7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 19	Year)	Countr	ace (State or y) Y	Foreign		
Maryland 28a-f show otified at	irector	10a. State 10b. County Montg		City, Town or Lo					. 10	od. Inside City			
with the s 23a or 3	Funeral Director	10e. Street and Number 6609 Pyle Road			10f. Zip Code 20817	,		I0g. Citizen of USA	What Count	ry?	_		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any righty or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	N. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🐴 No	ın, Mexican, Puert	oecify Yes or No- o Rican, etc.)	BI	ce - America ack, White, et White y:	to			
within 72 hou giene. er than "natu the Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life. D	dent's Usual Occup kind of work done o OO NOT use retired) emaker	ation during most of wor	rking	16b. Kind of		ustry			
d be filed vental Hygurked other	To Be	17. Father's Name (First, Middle, Last) Thomas Joseph Cost	ello				me (First, Middle, M ura Klip		ne)				
d 2 should salth and N 27 is me er trauma		19a. Informant's Name/Relationship (Type Sharon Hawkins/Dau			ng Address (Street a					ode)			
Page 1 an nent of He ant: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		osition (Name of matory or other place tan Crema	; NO	y 14, 2011	20c. Location	,				
permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	0441	F.	Pane and Address Tancis J. 00 Univer	sset5acilins	Funera1	Home I	Inc. Spring	, MD 2	20901		
Physician/		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the dicause on each line.	•	er the mode of dyin	g, such as cardiac	or respiratory arre	st,		Approximate Interval Betw Onset and D	veen		
Medical Examiner	ı.	resulting in death) Sequentially list conditions, b.	Due to (or as a cons										
be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a cons										
ficate be e g physicia as the bur	l edical	d.											
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. within 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	су			ate of deliver	,	'ear		
uires that the signed by the detailed be detailed by the detailed by the detailed by the detailed by the signed by		Part II. Other significant conditions control VPo TevS10V	ibuting to death but not	resulting in the	underlying cause giv	ven in Part I.	23e. Did tol	oacco use cor es 2 No	atribute to the				
The law requate has been page 2 shou	Completed by	RESPIRATORY FAILUR	E				24a. Was a autops perfor 1 Yes	med?	. Were autop prior to con death? 1 \(\subseteq \text{Yes} \)	npletion of ca	vailable ause of		
ysician: is certifica director,	To Be (25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	spital:	☐ ER/Outpatie	Oth	ace of Death (Che	ck only one)	ence 6 D O	her (Specify)	LIVIN	4		
arth. rr. After thi he funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year	28b. Time o injury	work	y at	28d. Describe ho						
tal or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe						ocation (Street and Number or Rural Route Number, City or Town, State)				
he Hospi in 24 hou he Funer ipletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Examiner 3 Certifying Nurse II	: On the basis of examina	ation and/or inves	stigation, in my opinio	on, death occurred	at the time, date ar	d place, and d	ue to the cau	se(s) and mar	nner stated.		
To t with To t		29b. Signatue and title of certifier	ere m		29c. License	o 86		29d. Date sign		ay, Year)			
2		30. Name and address of person who com	pleted cause of death (12201 Plu	macke	nØ	Silvens	Parg	MN à	10964			
Stat Registra		NOV 1 5 20	32. Registrar's Signature	gnature A	barker								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amond 200 1 - State Registrar E.H. TCHD, PRa 11/2/11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death a 8 Month Physician 2:35 AM 10 2011 Murra David /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Envo y /N Social Security Number Nursing Home Denton If Under 1 Year If Un If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex → 1 M 2 □ F 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 214-10-0936 Director 07-16-1919 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show notified at 1 Yes 2 No Director Md. aroline Venton 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or pe "natural", or items 23a 420 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 12. Was Decedent Ever in U.S. Armed Forces? by Funeral 14. Race - American Indian, id 2 should be filed within 72 hours after do the and Mental Hygiene. 27 Is marked other than "natural", or item traumatic event, the Medical Examiner. Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baker Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ reorge Margare 19a. Informant's Name/Relationship (Type. Print) 196. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is
any Injury or other trau 417 Cardine St., Denton, Nichols Thelma maryland 21629

20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) HURLOCK, Md. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 11-04-2011 Md. Veterans Cem. 21/Signature of uneral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover Street, EASTEN, Mary land 21601 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) WIDELY METASTATIL PROSTAYE ANCER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusito (or as a consequence of) burial-transit Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death signed by the a 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ ATRIAL 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 25 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) OOM WED ALL JUK 3+vA

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38353 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 28-2011 Charlene J. McMahan 825 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heartfields Talbot . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours Min. 1 □ M 2 🔀 F 4<u>~28</u>,_2% **Director** 238-50-3671 77 NC Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Talbot 1 🔀 Yes 2 🗌 No Easton 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 205 South Harrison Street 21601 IISA permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items
any injury or other traumatic event, the Medical Examiner mu
once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Secretary State of Georgia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Charles Lee McMahan Mabel Clara Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheril S. Thomas (Daughter) 205 S. Harrison Street Easton MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Chesapeake Cremation 10/31/2011 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home P.A.
200 S. Harrison St. Easton MD 21601 MERCEROR 2 OHOK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Deat Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Asst. Living 28a. Date of injury (Month, Day, Year) funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 🗌 Yes Accident 2 No completed filled in by the Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CRNP 124/98 2211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTON, MD

Registrar

State

gistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11:10P November 2011 Robert Wilson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Sykesville Fairhaven 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Sept 5, ^{Year)} 1916 Months Days Min 299-10-2211 Director 1x M 2 □ F Pennsylvania 95 Usual Residence of Dec 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Sykesville Carroll 1 Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21784 7200 Third Avenue 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 07. þ 1 Never Married 2 Married 1 Yes I 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 X Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) within 72 Elementary/Secondary (0-12) College (1-4 or 5+) **US Navy** Commander should be filed with h and Mental Hygien 7 is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cotton ပ Lorraine Wilson McKee Thomas and 2 should be Health and Metern 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1114 East Jefferson Street Charlottesville, VA 22902 Robert Butler McKee/son item 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Ardent Cremation Svc 11/14/2011 4 ☐ Donation 5 ☐ Other (Specify) Hanover, Maryland 22. Name and Address of Facility Harry H. Witzke's Family FH. Inc ure of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ad demen Physician/ Nanco Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical law requires that the death certificate be Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Month Dav Year Yes 2 No be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate 2 🗌 No Yes 2 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA X Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director; After it 1 Natural 5 Pending 1 🗌 Yes 2 🔲 No ☐ Accident ☐ Suicide Investigation filled in by the 8 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar

Medical

29a. Certifier (Check

only one

29b. Signature and title of certified

Ana Sarante, M.D

NOV 1 4 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1645 Liberty Rd. Eldersburg, Md. 21784

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1005405

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar 38355 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charles Ray Moody 1525 M 2011 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner REGIONAL TENINSHLA CENTU 542136419 KILOMICO Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 214-50-0486 **Director** 1 X M 2 | F 63 12/26/1947 West Virginia Usual Residence of Dece 10a. State 10h County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Numbe ö 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 32601 Johnson Road 21804 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Examiner Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Army
Year or Dates. Black, White, etc. 9 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify: "natural", Completed 3 Divorced Specify: White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Owner Cleaning traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers ပ William Moodv Helen Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32601 Johnson Rd., Salisbury, MD 21804 of Health a item 27 i Carol Moody/Spouse other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place. 0 1 XBurial 2 Cremation 3 Removal from State Department or Important: If any injury or once. New Hope Cemetery 11/7/2011 Willards, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a, Part 1. Enter the disease, or complications that Fused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause or Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence oi). and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical law requires that the death certificate be Box 68760 as the attending IF FEMALE: nse s 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Lyes 2 L 9 Unknown Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy death? performe 1 ☐ Yes 2 🗷 No ☐ Yes 2☐ No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗶 No 1 Yes Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify Director: After this in by the funeral of 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending death 1 🗌 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after determined Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examiners on the basis of examiners and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Certifying Nurse Practitioner: To th best of my t owledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 7 29d. Date signed (Month, Day, Year) D69634

State Registrar

IUTE

Carroll

21801

ompleted cause of death (Item 23a) (Type, Print)

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32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38356 State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month John R. Molenda 9:45 November 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 309 North Blvd. Salisbury Wicomico Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7 Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 210-22-2519 1 🕱 M 2 🗆 F 80 04/12/1931 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Wicomico Salisbury 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 North Blvd. 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Was Decedent Ever II
Armed Forces?

1 X Yes 2 No
If Yes, Give Army
Year or Dates. Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Professor of Microbiology University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John J. Molenda Anna Seashock 19a. Informant's Name/Relationship (Type, Print)
Carolyn Molenda/Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 North Blvd., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State emetery, crematory or other place) Salisbury Crematory 11/7/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 \(\text{Yes} 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 - Nursing Home 5 Residence 6 Other (Specify)

Physician/ Medical Examiner Examine

Physician/

Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

28a-f show

er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

Hygiene.

should be filed with and Mental Hygien is marked other th

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

injury or other traumatic event,

Maryland 21215-0036

Baltimore,

Hospital or Attending Physician: The law requires that the death certificate be executed physiciar the use as signed by page 2 s funeral

Physician/Medical

þ

Completed

Be

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27. Manner of Death

Division of Vital Records, P.O. Box 68760 28a. Date of injury (Month, Day, Year) Certificate: 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 129105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christjon Huddleston, M.D. 31. Date filed (Mo

106 Milford St., Suite 103, Salisbury, MD 21804

28c. Injury at

28d. Describe how injury occurred

State Registrar Day, Year) 08

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **JAMES** P. MANOGUE 6:08PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice at Nicomic bury 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours 221-28-8452 **Director** 68 1 🔀 M 2 🗆 F 09/24/1943 Delaware Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Delaware Seaford 1 Yes 2 XNo Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22675 Atlanta Rd 19973 US 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No ☐ Yes 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry oe filed win. ⁴at Hygiene. ⁴er than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bank Manager Banking and Mental Hygie is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) ഉ Larry Manoque Elizabeth Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Eleanor Manoque- wife O Box 611, Seaford, DE 19973 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State matory or other place)
Crematory 1
Burial 2
Cremation 3
Removal from State Capitol 11-0802011 Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Price Licens

John A. Cranscon O Box 967 22. Name and Address of Facility Cranston Funeral Home Seaford, DE 19973 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ca -cedisease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has a funeral director, page 2: autopsy death? 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 ☐ Yes No Other: a Sother (Specify) Hughice မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No Natural iniury 5 Pending Accident
Suicido Investigation
6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D63199 11/6/11 Name and address of person who completed cause of death (Item 23a) (Type, Print) SHORE DR. SAUSBURY, MD. CASTERN 066 31. Date filed (Month) Registrar's Signa Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Day 10:32 AM FRANCES MADDEN Μ. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death -durel Regional Hospita -aure Prince (reorge's Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) 1 □ M 2**X** F Months Days Hours Min. July 6, Director 249-48-0156 81 SC Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MD Prince George's Landover 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2310 Matthew Henson Ave 20785 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Pastor Private Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Marion Bell Mamie Ethel Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2310 Matthew Henson Ave, Landover, MD 20785 Fred Madden/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Red Hill Baptist Church Cemetery 1 👿 Burial 2 🗆 Cremation 3 🛣 Removal from State Gadsden, SC 4 Donation 5 Other (Specify) 11/23/2011 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licens 5538 Marlboro Pike, Forestville, MD 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ HYPOXId Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): cute To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? AndSarcd 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy Bradycardia Yes 2 No 2 **N**o 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No Accident 1 Tyes Investigation 2 Acciden
3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D0012962 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van aurel Regional Llager MD Zoraydd Lee-State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 38359 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Worth Wemps Physician/ Year Robert Montgomer 1806 9 2011 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death Maryland Prince outhern Hospital 11 MON, MD Georges Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. **Funeral** Days Director 1 🖾 M 2 □ F 577-76-8208 58 June 3, 1953 DC Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director items 23a or 28a-f s ner must be notified 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 4687 A Street SE 20019 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iter Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked any injury or out. Yes 2 X No African 1 ☐ Yes 2 A No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Verizon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lawrence Montgomery Ruth Mary Wilson 19a. Informant's Name/Relationship (Type, Print) Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 3418 Gateshead Manor Way # 202 Douglas M. Gilchrist Jr. -Silver Spring, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State cemetery, crematory or other place) Nov. 4 Donation 5 Other (Specify) Lee's Crematory Clinton, Maryland of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Benning Road NE Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, Myocardia disease or condition immediate Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Dav Pregnant at time of death Other (specify) signed by the a 1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed this certificate has Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Tes 2 - No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0061131 November ne and address of person who completed cause of death (Item 23a) (Type, Print) eather

DHMH 17 Rev 06-2011

State Registrar 11-08283

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physici	an/	Decedent's Name (First, Midd	le,Last)	- · · · · ·			 	2. Date of D Month	eath		3. T	ime of Death
"~dical Exam	iner	Delonte Dia 4a. Facility Name (if not institution	nthony	Mckie				Novemb				2141 hrs
		4a. Facility Name (if not institute Route 50 at Route 70		nber)		4b. City, Town, or I Lanham	Location of Dea	ith		c. County of Decrince Geo		
Francis	-	5. Social Security Number		7. Age (In yrs. I	last hirthday)	If Under 1 Year	If Under 24H	rs 8 Date of		/DD/YYYY) 9.		ce (State or
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0036 within 72 hours after death with the Maryland jene. ter than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	亨	8648 Fulton	Ave			20706			Uni	ted S	tate	es
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21215-0036 suld be filed within 7 Mental Hygiene. marked other than	S	17. Father's Name (First, Middle	, Last)		110.		8.Mother's Nar	ne (First, Middle				
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ID 21 should and Me 7 is ma	욘	19a. Informant's Name/Relations				g Address (Street				•		
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Baltimore, permit. Pages 1 a Department of He Important: If ite		1 X Burial 2 Cremation	n 3 Removal fro	m State	crematory or ot	her place)	<i>"</i>					
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Physic Physic er this eral dir	유	1 ✓ Yes 2 No 27. Manner of Death	28a. Date o	patient 2	ER/Outpatient 28b. Time of I		4 ∐ Nurs y at Work?	28d. Describ			ther: Sce	ne
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Division of Vital Records, ral or Attending Physician: The law requints after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the control of the con	Eal		stigation 28e. Place	of Injury - At h	ome, farm, stree	et, factory, office bu	uilding, etc.	28f. Location	(Street a	and Number or	Rural R	oute Number, City
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medicai Exa	miner: On the basis of and manner sta	examination a ited.	nd/or investiga			at the time, da				
	Ž	29b Signature and title of certific	A			29c. License				Date signed (Pay, Year)
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0 1		Name and address of person				altimora Stract	Raltimore	MD 21222				
~		Laron Locke MD. A 31. Date filed (Month, Day, Year)	ssistant Medical			ailiniore Street	, Daitimore,	IVID 2 1223				
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 20b per fh G922 12/1/11 dk
State of Maryland / Department of Health and Mental Hygiene 38361 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death //48 M Physician/ Maphis Richard Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Western Marland Regional Medical (tr. Allegany Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpia Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) Jun 3, 1944 235-70-2944 Usual Residence of Deceden **Director** 1 🗶 M 2 🗆 F 67 28a-f show 10a. State 10b. Count ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Allegany Cumberland MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21502 Allegany Health and Rehab Center 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify. "natural" Completed 3 ☐ Widowed 4 🙀 Divorced white Year or Dates. Vietnam 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the truck driver trucking company traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file lith and Mental H 27 is marked o မ Dorothy Ellen Brown Raymond Frederick Maphis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 siment of Health a tant; If item 27 i James Maphis HC 65, Box 3110 Springfield WV 26763 brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/20/11 14/26/2011 permit. Page 1
Department of
Important; If it
any injury or o 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 Departion 5 Other (Specify) WD Scarpelli Funeral Home, P.A resantown 21. Sonature of Funeral Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY Ph_sician/ DAYS FAILURE Medical **Examiner** OBSTR CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of) attending physician I for use as the buris Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year be detached the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed.

Yes 2 No 24 hours after death. Funeral Director. After this certificate 2 No 1 🗌 Yes Division of Vital the Hospital or Attending Physician: director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 - ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I ည -14864 Aomo pleted cause of death (Item 23a, (Type, Print) 30. Name and address of person who con Jr. Mp 200 Glenn St. Ste. 302 Cumberland, NID 21502 Robustiano arrera gistrar's Signature State Registrar

The

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38362 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day CATHERINE CHRISTINE MESSERMAN 201 VIO Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City Town, or Location of Death Joseph Richey Hospice Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min. 216-01-1839 92 Yrs. **Director** arvland Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No MD. Harford Bel Air 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 1231 Conowingo Road 21014 United States 12. Was Decedent Ever in U.S. Was Decedent ___ Armed Forces? 4 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygien 0 Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Simon -Beolt K1ine Christine Beck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau Clifford Tellis (Son) 2201 Bank Street Baltimore, 20a. Method of Disposition
1 □ Burial 2X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Hampstead, 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each Me. Approximate Interval Between Onset and Death Immediate Cause (Final thre Physician/ disease or condition - Medical resulting in death) a consequence of) * Examiner -45-8 Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Month Day Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes Yes Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? Natural within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 🗌 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat re and title of certific 11 who completed cause of death (Item 23a) (Type, Print) HOOKINS 31. Date filed (Month Pay, Year) State Registrar

5 DHMH 17 Rev 7/2009

Catherine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death Physician/ November 21 2011 6:36 а м Lillie Morsell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Calvert County Nursing Center Prince Frederick Calvert 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🖼 F Davs Hours April 9, 1914 MD Director 219-12-4563 Usual Residence of Decedent or 28a-f show 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 675 Ponds Wood Road 20639 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. "natural", or þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☑ Divorced Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Harold Gardner Mary Earle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Edward Moore - nephew Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other 1 Burial 2 Cremation 3 Removal from State Mt. Gethsemane Holiness Chr. Cem. | November 26, 2011 | Huntingtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Glade 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ongeslive Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Por in the past 12 months' Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 Yes Be 25. Was case referred to medica examiner? 26. Place of Death (eck only one) Hospital: Other: မ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) f Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending work? 1 ☐ Yes 2 ☐ No М Accident Investigation within 24 hours after deatl To the Funeral Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occ curred at the time, date and place, and due to t 29b. Signature and title of certifig 29d. Date signed (Month, Dav. Year) 00194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21058

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

11-08601 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 38364 State of Maryland / Department of Health and Mental Hygiene George Irving Masser 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day November 15, 2011 1930 hrs Medical Examiner George Irving Masser, Sr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Washington Meritus Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 217-30-7208 Country Maryland 1X M 2 F 05/11/1934 77 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny 10a. State 10b. County 1 Yes 2 X No Maryland Smithsburg Washington filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code s 23a or 28a-110 Patrick's Court <u>United States</u> Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 X No 9 1 Yes 2 X No specify: Specify: White 3 X Widowed 4 Divorced If Yes, Give Year ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene.
marked other than "sic event, the Medical R Baltimore, MD 21215-0036 Owner/Operator Auto Body Repair 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oscar V. Masser Beulah V. Blank Health and Mental mit. Pages I and 2 should be a partment of Health and Mental portant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8596 Mansfield Court, Middletown, MD 21769 George I. Masser. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Rocky Springs Cemetery 11/22/2011 Frederick, Maryland 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee Reeney and Bastord PA Funeral Home M01473 Church Street, Frederick, Approximate Interval art Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Torso Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exam (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medica **AMENDED** attending physician for use as the burial -UNPENDED of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 3b. Was decedent pregnant in the Day 1 Live birth Fetal death 3 Ectopic pregnancy Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown n signed by the a d be detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy death? Yes 2 No 1 🗸 Yes certificate 2 No director, page 26.Place of Death (Check only one) 25 Was case referred to medical Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗍 DOA Other Nursing Home 5 Residence 6 Other this 1 Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred After 27. Manner of Death <u></u> Subject passenger in auto auto collision Nov 15, 2011 1739 hrs 1 Natural 1 Yes 2 ✓ No 5 Pending Certificati 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 11716 Mapleville Road, Smithsburg, MD determined 4 Homicide (Specify) Local Street

Division Director: hours after death. the Funeral 24

one)

and manner stated 29b. Signature and title of certifier nassa C 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD

November 16, 2011 O.C.M.E.

29d. Date signed (Month, Day, Year)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c, License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

NUA 3

31. Date filed (Month, Day, Year)

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dorothy Nigrine 2011 9:00P Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3601 Queen Mary Drive Olney Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days **Director** 482-20-2703 1 □ M 2 🛛 F 85 Nov. 21 1925 Usual Residence of Decede 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Montgomery 01ney 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be i Funeral 3601 Queen Mary Drive 20832 United States and 2 should be filed within 72 hours after death 1 Health and Mental Hygiene. tem 27 is marked other than "natural", or items xther traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🕱 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify. Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Editor Publishing 12 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Henry Bregman Thiede Verna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Henry Nigrine / Husband 3601 Queen Mary Drive, Olney, Maryland 20832 other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Department of H Important: If ite any injury or of 20c. Location - City or Town, State Page 1; 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 11/08/11 Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home Laytonsville, Maryland 20882 Box 5038, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Multisystem Organ Failure week Medical resulting in death) Examiner 3 years Coronary Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Date to (or as a consequence of): Examin burial-transi death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Dav Year signed by the at Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peripheral Vascular Disease Division of Vital Records, Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown plnods Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 death? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗹 No Other: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely . To the within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and tithe of 6 29d. Date signed (Month. Day, Year) 0035045 November 8, 2011 30. Name and address of person w completed cause of death (Item 23a) (Type, Print) 40 Philip G. Henjum, M.D. 18109 Prince Philip Dr., #200, Olney, MD 20832 31. Date filed (Mon 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Day 5, 2011 Regina L. Neal Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Henson Avenue Landover 2214 Matthew Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month, Day, Ye 1 🗆 M 2 🔀 F Months Days Hours Min **Director** 216-74-5689 ,1961 Wash 50 June Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Landover MD PG 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20785 2214 Matthew Henson Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. iem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Private Insurance Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Florine Edelin Samuel Miller 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 23rd Parkway #T3 emple Hills, MD 20748 Tyrinda Miller/daughter permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 11/15911 cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton, MD Signature of Funeral Service Licensee Edwards F.H. 22. Name and Address of Facility Hodges & 3910 Silver Hill Rd., Suitland, MD.20746 Part II. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 20 MINT Staf Immediate Cause (Final Unethras Physician/ 9 0 month disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) burial-transi been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) after death.

Director: After this in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d, Date signed (Month, Day, Year) 10 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) Woodward Rd. Clinton, MD 20735

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ A M 2011 0807 November Ernest Paul Null Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Ceci1 North East 331 McKinneytown Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 19<u>55</u> Month, Day, Days 1 X M 2 □ F Maryland Director 56 217-60-4197 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland notified at Director 1 ☐ Yes 2 🔀 No 28a-f Maryland Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö r than "natural", or items 23a o the Medical Examiner must be Funeral 21901 United States 331 McKinneytown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married 2 XNo Completed by ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White If Yes, Give 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Trucking ?7 is marked othe traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any linjuy or other traumatic event once. 17. Father's Name (First, Middle, Last) ၉ Inez Harmon Jacob A. Null 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine Jamison Null/Wife 331 McKinneytown Road, North East, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Gilpin Manor
Memorial Park 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November Elkton, MD 22 2011 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bladder Cancer Physician/ disease or condition resulting in death) Netastate Medical Due to (or as a consequence of): Examiner Tobucco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Records, Diabetes Mellitus II Hyper hordenia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy performed? 1 ☐ Yes 2 🕱 No 1 Yes 2 No Comany Artery Disease Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be examiner? Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide injury work?
1 Yes 2 No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29b. Signature and title of certified 29c. License number D26392 November 21, 2011 Private Physician

State Registrar

DHMH 17 Rev 7/2009

111 West High Street

Elkton MD 21921

Suite 314

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a.D

. Registrar's Signa

T. Teal

1-08278	Please Type or Print in Black Indelible Ink. Ensure All Cop	ies Are Legible.			
ames Clark Palmatary	State of Maryland / Department of Health and Mental I	Hygiene	201	1	3836
1- For State Registrar	Certificate of Death	Reg. No.		•	0000
Physician/ 1. Decedent	s Name (First, Middle,Last)	2. Date of Death		3. Time	e of Death
Andical Examiner Ta	C1 1 - D - 1 +	Month Day	Year	154	45 hrs

		Registrar			entificate d	or Dea	in				Reg. No.			
Physicia		1. Decedent's Name (First, Midd James Clark								Date of De Month Novembe		Year		3. Time of Death 1545 hrs
		4a. Facility Name (if not institution Black Walnut Point R	on, give street and nu	mber)			, Town, or Lo	ocation of			4c.	County o	f Death	
_	-			7. Ann (In	s. last birthday)	_		If Under	241) 1	O Data of D			l o n:-u	nplace (State or
Funeral Director		5. Social Security Number 219-31-6044	6. Sex	7. Age (in yrs	• /	Mon	ths Days	Hours		03-28			Foreign	ntry) MD
	ı	Usual Residence of Decedent												
any		10a. State 10b. County		10c. Ci	ty, Town or Loc	ation								10d. Inside City Limits
ne Maryland nr 28a-f show ffed at nnce.	5	MD Tal	.bot		Easto	n								1 X Yes 2 No
Maryl 28a-	Director	10e. Street and Number				10f. Z	ip Code				10g. Citiz	en of Wh	at Count	try?
ith the 23a nr notifie		29506 Golton	Drive			1	2160	1				USA		
h with	uneral	11. Marital Status	12. Was Dec				dent of Hispa cify Cuban, I				0-	14. Race White		an Indian, Black,
nr ite	핇		1X Yes	2 No	· I					,				
s afte	<u>a</u>		or Dates:				2X No		-1-5	la deserva		Specify:		ite
2 hours afte "natural", Examiner	ted	15. Decedent's Education (Spe Elementary/Secondary (0-12)			16a. Decede during		orking life. [10b. K	ind of Bus	siness/in	laustry
MOVE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Inter of Health and Mental Hygiene. Inter If item 27 is marked rither than "natural", ur items 23a nr 28a-f shown the renumstic event, the Medical Examiner must be notified at more.	Completed	12	College (1	-4 OI 3+)	Range	er					Uni	ted	Stat	es Army
21215-0036 wld be filed within 7 Mental Hygiene. marked nither than c event, the Medica	팃	17. Father's Name (First, Middle	, Last)				18	3.Mother's	Name (F	irst, Middle,				
215 e file tal Hy ked n	Be	James Elwood	Palmatary	Jr.				Lisa	a Ber	nningt	on			
Men Men	9	19a. Informant's Name/Relations			19b. Maili	ng Addres	ss (Street a	- Carrier			-	y or Towr	, State,	Zip Code)
MD 1d 2 shoulth and m 27 is aumativ	1	James E. Palma	tary, Jr.	(Fathe	r) 295	06 G	olton	Driv	e E	aston	MD .	21601	L	
G, E		20a. Method of Disposition 1 Burial 2 X Cremation	. □ B (· ·	o. Place of Dispo crematory or o	ther place	<u> </u>			Date	20c. L	ocation -	City or T	own, State
Pages ent of ut: I		1 Burial 2 X Cremation 4 Donation 5 Other S		CI	hesapeal	ce Cr	emati	on 1	11-6-	-2011	St	even	svi1	le, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Figures. Important: If item 27 is marked other than injury or other traumatite event, the Medical	Ì	21. Signature of Funeral Service		0 - 1	7 22	Name an	d Address o	t Facility	nain	& Not	mam	Fune	ral	Home P.A.
E.E.G.E.O		13 Keith	H trow	1-54	120	00 S.	Harr	ison	St	East	on MD	216	01	nome 1.71.
Physician		23a. Part I. Enter the disease, or failure. List only one cause		used the dea	th. Do not enter	the mode	e of dying, su	uch as care	diac or re	espiratory ar	rest, sho	ck, or hea	rt	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease	a. Contact Sho	otgun Wou	und of Head									Death
		or condition resulting in death)	Due to (or as a	consequence	e of):								- 1	
	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	e of):								$\overline{}$	
_	튑	cause Enter Underlying Cause (Disease or injury that initiated	С											
ited d ansit	Examine	events resulting in death) Last	Due to (or as a	consequence	of):									
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8760, tificate be ng physici as the buri	ĕ	IF FEMALE:	23c. If yes, o	utcome of pre	egnancy						23d	Date of	delivery	
687 certific iding p		23b. Was decedent pregnant in the past 12 months?	L Cive Di			etal death	h 3	Ectopic p	oregnanc	у		Month	Da	ay Year
O. Box 687 at the death certific by the attending prached for use as the	Physicia	1 Yes 2 No 9 Uni		ant at time of	death 5	ther (Sp	ecify)							
the d	튑	Part II. Other significant condit			t resulting in the	undertvir	na cause giv	en in Part	I.	23e. Did	tobacco u	se contrib	oute to th	ne cause of death?
ires that signed I be deta	<u>اھ</u>				•	•				1 Ye	s 2 🗸	No 3	Proba	ably 4 Unknown
ords, w require s been si	Completed								_	24a. Was	an	24b. W	ere auto	opsy findings available
law r has b	힑				<u> </u>					auto	psy orm <u>ed</u> ?		ior to co eath?	mpletion of cause of
ital Recicion: The scertificate	ខ្ញុ		· · · · · ·				<u>.</u>			1 Yes	2 No	1	✓ Yes	2 No
of Vital Records, P.O. of Physician: The law requires that the third returns the law requires that there is contificate has been signed by neral director, page 2 should be detacted.	8	25. Was case referred to medica examiner?	Linearitals	patient 2	ER/Outpatier		26.Place o	thor -		y one) Home 5	0	0.57		0
Phys er thi	의	1 Yes 2 No 27. Manner of Death	28a. Date o		28b. Time of		28c. Injury			d. Describe	,		_	Scene -
ading Pt th.	Certification:	1 Natural 5 Pend	dina FOUND:	Day,Year)	FOUND:	,,	I _ `	s 2 🗸 N	ls:	bject sho		, 0000,10	•	
Division tal or Attendi rs after death.	<u> ă</u>	2 Accident Inves	stigation Nov 4, 20		1535 hrs home, farm, str	eet, factor	rv. office bui	idina, etc.	28	f. Location	Street an	d Numbe	r or Rura	al Route Number, City
Div pital or ours afte neral Di	遺		d not be	In truck o		,	,,			or Town, ack Walnu				
		20a Cartifier	hysician: To the best			urred at th	ne time, date	and place					_	
To the Howithin 24 h To the Fur	Medical	10/100/10/10/	miner: On the basis o	f examination	-									
1	ž	29b. Signature and title of certifie				29	9c. License r	number			29d. D	ate signe	d (Mont	h, Day, Year)
1L5		- 1/					O.C.M	.E.			Nove	ember 5	5, 2011	1
5+VA COME	+	30. Name and address of person	who completed cause	e of death (Ite	em 23a)					120.11				
		Mary G. Ripple MD.	Deputy Chief M			0 W. Ba	altimore S	Street, E	3altimo	re, MD 2	1223			
Sta Registr	-	31. Date filed (Morith, Day, Year) NOV 07 2		gistrar's Signa	ature	~						-		
77.77	- 1	11 V V V L			1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤿 38369 For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vincent Pizzi 0415 M COVEMBER 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Talbot Memorial Hospital at Easton Easton Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ 07-02-1924 87 Washington D.C. **Director** 578-20-6195 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MDTalbot Easton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 516 Trippe Ave 21601 USA death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ed 3 X Widowed 4 Divorced White Year or Dates other traumatic event, the Medical Complet 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Project Manager Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Verano Pizzi Brigida Collona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a: If item 27 is Vernon D. Pizzi 675 Santa Maria Lane Davidsonville, MD 21035 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Oxford Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11-07-2011 Oxford, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison St. Easton MD 21601 MERLEROX COHOL K. 200 S. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ multiora disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical P.O. Box 68760

Certificate:

IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be ည 1 Yes 2 0 No 27. Manner of Death Matural Natural 5 Pending Accident Investigation Suicide 6 Could not be 4 Homicide determined

23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an

				performed?	death? 1 \sum Yes 2 \sum No					
o medical			26. Place of Death (Chec	k only one)						
to .	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
i ☐ Pending Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury o	ccurred					
determined	e 28e. Place of Injury - At h building, etc. (Specif		ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Medical Exam	sician: To the best of my know iner: On the basis of examinations se Practioner: To the best of m	n and/or investigation, i	n my opinion, death occurred a	t the time, date and place, ar	nd due to the cause(s) and manner stated.					

29b. Signature and title of certifier Texternichael, Chemet. ME	29c. License number 072893	29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	, 219 S. WAShington	, St. Easton, md

Q+VA

Division of Vital Records,

Registrar

Medical

29a. Certifier

(Check only one)

eklem That 31. Date filed (Month, Day, Year) NOV 04

Certifying Physi

32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First Middle Last) Month **Physician** 5:05 a[™] 2011 Napoleon Prince 11 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Rockville Collingswood Nursing&Rehab. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Min. 1 1 M 2 □ F Months Days Director 188-28-8746 73 2-18-1938 Florida Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinan must be notified at 1K Yes 2 □ No Director MD Prince Georges Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7113 Poney Trail Court 20784 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after c of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Black. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Company Elementary/Secondary (0-12) College (1-4or 5+) 12th Electrician Princeton Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Faith Prince Mary Ingram ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) 7254 Mandan Road Greenbelt MD 20770 Juanita B. Prince-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal-from State 11-22-2011 Suitland, Maryland Lincoln Memorial 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral Home 21. Signature of Funeral Service Licen. 3005 12th Street NE Washington DC 20017 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complicance at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each e. Immediate Cause (Final hysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CUI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine the death certificate be executed that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy Month Day Year 5 Other (specify) I □ Yes 2 □ No 9 I Inknown Hospital or Attending Physician: The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? yes 2 2 No has To the Hospur...
within 24 hours after death.
To the Funeral Director: After this certificate 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Injury (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 6

State Registrar

31. Date filed (Month, Day NOV 1 82 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Pickles arlon 16, 2011 9:49 A M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 12610 Dalewood Drive 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo June 25, 5. Social Security Number Age (In yrs. last birthday, **Funeral** 1 ☑ M 2 ☐ F Days 80 Director June Maine 005 26 5462 Usual Residence of Decedent show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director ns 23a or 28a-f s must be notified 1 Yes 2 X No Silver Spring Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 IISA 12610 Dalewood Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten edical Examiner I 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No Completed by 1 Never Married 2 Married X Yes 1 Yes 2 No Specify: If Yes Give 3 Midowed 4 Divorced Year or Dates Army White er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Consultant Banking Industry is marked other aumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Pickles Hazel Mae Weston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah J. Pickles / Daughter-in-law 5733 Middleton Lane, Temple Hills, MD 20748 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important; If its any Injury or or once, ₽ cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery! 11/30/11 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gyann) Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Rogers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary Chronic Obstructive 16 years disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and tran Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical certificate be for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Live Birth 2 Liperar doc Pregnant at time of death in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 2 X No 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 2011 00012015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6492

Registrar DHMH 17 Rev 7/2009

State

Louis Steinbe

NOV 18

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Records,

Division of Vital

Landover Rd

Cheverly

38372

					Ce	rtificate	of L	Death		F	eg. No.		
	ъ.		1. Decedent's Name (First, Middle, Las	t)						2. Date of Dee		Voor	3. Time of Death
	Physic /Medi		Fred J	Pickett Jr.						North	er 16	Year	8'cy Am
3	Exami		4a. Facility Name (If not institution, give	street and number)			4	b. City, To	wn, or Lo	cation of Death	4c. County	of Death	
1			VILLA ROSA NURS	ING HOME			M	ттсн	FLIA	ILLE	PRIN	CE G	EORGE'S
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Birth	Yees)	9. Birthpl	ace (State or Foreign
	Director		5/9-54-3848	ĴM 2□F	70 Yrs.	Months E	ays	Hours	Min.	3/11	1941	NORT	ace (State or Foreign H CAROLIN
	p >		Usual Residence of Decedent									1	
	anyla sho	_	10a. State 10b. County	Toc. City	y, Town or Lo	cation						10	od. Inside City Limits 1 AYes 2 No
	Se-f	Sto		GEORGE'\$ L	ANDOV								
	il or a	Funeral Director	10e. Street and Number			10f. Zip Co	ode			1	0g. Citizen of	What Count	try?
	ath v	rai	7	RD			785				JSA		
	er de	Į,	11. Marital Status	12. Was Decedent Ever in U, Armed Forces?	S. 13.	Was Deceden If Yes, specify	t of His Cubar	sp <i>e</i> nic Ori 1, Mexicar	gin? (Spe 1, Puerto l	cify Yes or No- Rican, etc.)		e - America ck, White, e	
20	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give		1□Yes 2	No.	Specify:			Specif	BLAC	V
8	De filed within 72 hours after death with the Maryland ntal Hygiene. d other then "naturel", or itema 23e or 28e-f show event, the Mexical Examinar must be notified at	8		Year or Dates:	16a Dasse	dontin Havel C		A!					
5	in 72 i "nai	Completed	15. Decedent's Edu (Specify only highest grad	ie completed)	(Give	dent's Usual C kind of work o DO NOT use r	dona d	urina mae	t of workir	ng	16b. Kind of B	usiness/ind	lustry
12	filed with Hygiene. other then ent, the M	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)							_		
0	filed Hygi ent,		12th 17. Father's Name (First, Middle, Last)		CR	AIN O	PEF			(First, Middle,	PRIVA Maiden Surnan	TE —	
an	d be antal	Be c	FRED PICKETT S	D			_					,	
<u> </u>	d 2 should be filed within the and Mental Hygiene. 7 is marked other then traumatic event, the Mental Hygiene.	2	19a. Informant's Name/Relationship (T)		10h Mailie	a Address /C		EDNA		RE I Route Number	City or Town	State 7in	Code
Ma	d28 thar 7 is		MARGIE PICKETT/										
ē,	ges 1 and 2 t of Health If Item 27 i or other tr		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name	of		KD.,	LANDO Datel 1	OVER	City or Tox	ZU / 8 5 wn. State
altimore, Maryland 21215-0020	9 = = p		1 □ Burial 2 □ Cremation 3 □ F	Removal from State	emetery, crer	matory or othe MEMO	r place		EM 1	/22/	LANDO	VÉR,	MD
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			from H	Jun Ja						E NE W		DC 2	20002
		ě i	23a. Part. Enter the disease, or compleshock, or heart failure. Let only o	lications that caused the death ne cause on each lin	n. Do not ent	er the mode o	f dying	, such as	cardiac o	r respiratory arr	est,	i	Approximate Interval Between
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Division of Vital Records,	Attending Physician: or death. ector: After this certific by the funeral director,	ţ	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	м 200.	Injury Work'	? es 2∐1		od. Describe III	w injury occur	164	
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줊	after after Direction b	Certification:	4 ☐ Homicide determined	building, etc. (Specify,		set, factory, or	1100		-	City or Town		0, 0, 1,0,0	Tidate (Validation)
	spita ours nerel	a C	29a. Certifier 1 Certifying Phys	sicien: To the best of my know	vledge, death	occurred at th	ne time	e. date and	d place a	nd due to the ca	ause(s) and ma	nner as sta	ated.
	e Fur	edical	(Check only one) 2 Medical Exemination	ner: On the basis of examinati and manner stated.	on and/or inv	estigation, in	my opi	nion, deat	th occurre	d at the time, d	ate and place,	and due to	the cause(s)
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Euneral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title or sertifier			29c. Li	cense	number		2	9d. Date signe	d (Month, E	Day, Year)
			= Atlank	n as		0	00	533	37	1	Joseph	ier 1	772011
		-	30. Name and address of person who co	mpleted cause of death (Item	23a) (Type. I					11			
	5		Dowly Serry ni	75500	ith P	henue	S	ite zu	1 56	Baltir	nore, 11	1951	209
	Sta	re.	31. Date filed (Month, Day Year)	32. Registrar's Signat	ure								
	Registr	ar	NOV 1 8 2011 A	ma 10. 190	w								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38373 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year 5: 32 AM Jeffery D. Phoebus 10 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice at the Lake Salisburg Wicomico If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7 – 25 – 1948 **Funeral** 9. Birthplace (State or Foreign Country) 1 🕅 M 2 🗆 F Days Months Hours Min. Director 215-52-6507 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits Pittsville 1 Yes 2 XNo MD Wicomico 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o Injury or other traumatic event, the Medical Examiner must be Funeral Page 1 and 2 should be filed within 72 hours after death with 5080 Powellville Road 21850 Phoebus 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2X Married 21215-0036 2 X No 1 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: SpeciWhite 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Technician Electronics Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jesse M. Phoebus Virginia G. Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Mary L. Phoebus/Wife 5080 Powellville Road, Pittsville, MD 21850 20b. Place of Disposition (Name of cemetery, crematory or other diate) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Direct Cremation, 11-5-2011 Dover, permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Bennie Smith Funeral Home Salisb Isabella St. any isbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ MALIGNANI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy performer Yes 2 1 Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes ARNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 8416 10-31-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury,MD 21802 Ghulam Waris 926 Snow Hill Rd 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar recently

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar #31, Certificate of Death per hd, 11/14/11, ca 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Paul L. Prettyman, Sr. 7:19 AM M Nov. 10. 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11205 Griffin Road Berlin Worcester 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 □ F Director 214-28-7962 80 Dec. 22, 1930 Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. n 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ě r 28a-f sh notified 1 ☐Yes 2 No Directo Md. Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 11205 Griffin Road 21811 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Neyer Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ Specify: 3 ₩idowed 4 Divorced White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Seafood and Agriculture <u>Waterman</u> and Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Prettyman ၉ Mattie Bradford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Tammy Dryden 555 Greenbackville Road, Stockton, Md. 21864 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important; If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, Maryland 21. Signiture of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home MO0295 11673 Somerset Ave, Princess Anne, Md. 11. Enter the disease, or complications that caused the death. lock, or heart failure. List only one caus, on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ediate Cause (Final CEll etastatic Physician ease or condition sulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi the death certificate be execute and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of performed death? 1 ∐ Yes certificate 1∐ Yes 2 No 2 No Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this f Death 27. Mann 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funeral 28c. Injury at Work? Hospital or Attending 24 hours after death. Division 1 Matural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of of death (Item 23a) (Type. who completed cause 31. Date filed (Month, Day, 32. Regiş State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09 1:20 ie 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Washington Medical Washington Prince Georges If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months 66 **Director** 28a-f show 10b. County . Page 1 and 2 should be filed within 72 hours after death with the Maryland timent of Health and Mental Hygiene. It ant: If item 22 75 is marked other than "natural", or items 23a or 28a-f sho iury or other traunatic event, the Medical Examiner must be notified at jury or other traunatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕽 No 10g. Citizen of What Country? 10e. Street and Number by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 XYes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Koom Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Home IK Funeral f Funeral Service Lic 21. Sign nuré reene Alexandria, V+22314 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part 1. Enter the disease, or complicate Approximate shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 No 3 Probably After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy completed filled in by the funeral director, page 2 performe Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 1 Inpatient 2 ဂ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural work?
1 Yes 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a. Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 54723 impleted cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

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		1- For State Registrar		te of Death	Reg. N	20	11 383				
Physici cal Exami		Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death				
cai Exami	ner	Marcus Anthony Pa	ırham		Month Day November 9,		0902 hrs				
		4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center		4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George					
Funeral			In yrs. last birthd		To Date of Right/M	M/DD/YYYY) 9. Bir					
Director		577-19-0684 1 N 2 F	26	Months Days Hours Min.	1	Foreig					
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any			Oc. City, Town or	Location			10d. Inside City Limits				
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faryla 28a-f i at o	Director	10e. Street and Number		Washing		itizen of What Cour	ntry?				
the N	ä	4425 Quarles Street NE		United	States						
permit. Pages I and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Braminer must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Eve	er in U.S. 1	20019 13. Was Decedent of Hispanic Origin? (Spe		14. Race - Ameri	can Indian, Black,				
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ould b I Men	٩	19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (Street and Number or Ru			Zip Code)				
oernit. Pages I and 2 sho Department of Health and Important: If item 27 is njury or other traumati		Gloria J. Parham - Mother 4425 Quarles Street NE Washington, DC									
l and Heal Fiten		20a. Method of Disposition	20b. Place of D	Disposition (Name of cemetery,	Date 200	. Location - City or	20019 Town, State				
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mit. 1 ports ury o		21. Signature of Funeral Service Licensee		Harmony 2 22. Name and Address of Facility Ste	011 I	andover,	Maryland				
ELGE		John T. Stewart	25	4001 Benning Road N	E Washir	gton, DC	20019				
hysician		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	death. Do not er	inter the mode of dying, such as cardiac or r	respiratory arrest, sl	nock, or heart	Approximate Interval				
/Medical ≟xaminer		Immediate Cause (Final disease a. Multiple Gunshot V	Nounds				Between Onset and Death				
		or condition resulting in death) Due to (or as a consequence)	ence of):								
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ficate be exe g physician a the burial -	힔	UNPENDED AMENDED									
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that the ned by detache	b P	Fart II. Other significant conditions contributing to death but	t not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?				
ires that signed	힣				1 Yes 2	✓ No 3 Proba	ably 4 Unknown				
ng Physician: The law requires that it the this certificate has been signed by uneral director, page 2 should be detact	Completed				24a. Was an		opsy findings available				
he law te has	٤				autopsy performed?	death?	empletion of cause of				
n: Ti		25. Was case referred to medical		26.Place of Death (Check onli	1 Yes 2	Vo 1 ✓ Yes	2 No				
ing Physician: The law After this certificate has l uneral director, page 2 st	e Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ER/Outpai		Home 5 Resid	ence 6 Other:					
ding Ph	⊢⊦	27. Manner of Death 28a. Date of Injury			Bd. Describe how in						
endir sath. or: A	힐	1 Natural 5 Pending Nov 9, 2011	0825 hrs	rs 1 Yes 2 ✓ No St	ubject shot						
or Attend fler death. Director: in by the	<u>≅</u>	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm,	street, factory, office building, etc. 28	3f. Location (Street	and Number or Rura	at Route Number, City				
pital or Attendin ours after death.	₽1	4 Monicide determined (Specify) Apartm			or Town, State)	t NE, Washington					
		29a. Certifier 1 Certifying Physician: To the best of my kno	owledge, death o	occurred at the time, date and place, and du	ue to the cause(s) a	nd manner as stated	1.				
Fo the within Fo the omple	Medical	one) 2 Medical Examiner: On the basis of examinar and manner stated.	tion and/or inves	stigation, in my opinion, death occurred at th	he time, date and pl	ace, and due to the	cause(s)				
	Ž	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Mont	h, Day, Year)				
		Carol Hollo	La-	O.C.M.E.	No	vember 10, 201	11				
$_{i}$	1	30. Name and address of person who completed cause of death	(Item 23a)								
<i>t</i>		Carol Allan, MD Assistant Medical Examine	er 900 W. I	Baltimore Street, Baltimore, MD	21223						

DHMH 17 Rev 1/2001 OCME 2006

State 31. Date filed (Month, Dayler)
Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #18 Per FH G923 1/05/2011 Jh

State of Maryland / Department of Health and Mental Hygiene 2 0 1 1

			For State Registrar	State of Mary		tificate of E			Reg. No.	11 30311		
	Dhysisis	.m/	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath Day	3. Time of Death		
f a	Physicia Medio		Madeline J. Pear			T		Novemb	1	011 1:00 P ^M		
	Examin	er	4a. Facility Name (if not institution, give		200	Freder	Location of Death		4c. County of Death Frederick			
777	Funeral		Northampton Mano 5. Social Security Number 6. S		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthplace (State or Foreign		
	Director		213-42-2085 Usual Residence of Decedent	□ M 2 X F	92 Yrs.	Months Days	Hours Min.	(Month, Day March 1	4, 1919	Maryland		
To de	ishov dat	호	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits		
A C	28a-	Director	Maryland Freder	ick	Jeffers					1 🗆 Yes 2 🗓 No		
4	s 23a or ust be r	Funeral C	10e. Street and Number 4150 Mountville	Road		10f. Zip Code 21755			10g. Citizen of Wh United S			
036	permit. Tage 1 and 2 should be made which 12 hours shert beath with the Maryland permit. Tage 1 and 2 should be made within 12 hours after being 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 🏋 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White		
21215-0036	e. Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d O NOT use retired)	ation Juring most of work	ing	16b. Kind of Bus	iness/Industry		
2	ygiene ygiene her th t, the		9			Homemaker			Own H	lome		
Maryland	Aental Hi	To Be	17. Father's Name (First, Middle, Last) George W. Piper				18. Mother's Nam Mary	e (First, Middle, Welby I				
lary	and N is me		19a. Informant's Name/Relationship (1	ype, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	al Route Number	; City or Town, Sta	te, Zip Code)		
e, 7	and a Health Sm 27 Sm 27 Sher to		Bernice Jockisch		5 Loc		1 /	-1		ryland 20905 lity or Town, State		
Baltimore,	ment of h		1 X Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State	cemetery, crent. Paul	natory or other place Cemetery	20	Ber 26,	Jeffers	on, Maryland		
Balt	Depart Import any inj		21. Signature of Funeral Service Licen	1	1473 1 1473 1	Name and Address eeney and 06 East 0	d Bastord	PA Fun	eral Homored	e, , MD 21701		
4		П	23a. Part 1. Enter the disease or comshock, or heart failure. List only of	plications that caused the d	eath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between		
. Pl	n sician/		Immediate Cause (Final disease or condition	Ceret	no Va	senlar	Acerd	Cents		Onset an Death		
	Medical xaminer	П	resulting in death)	Due to (or as a cons								
		iner	Gequer tially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):							
cuted	transit	Examiner	Cause (Disease or injury that initiated events	c	- Carrena et							
1 760 icate be executed	physician and s the burial-transit	cal E	resulting in death) Last	Due to (or as a cons	equence on.							
3760 ficate b	D 66	Nedi		d								
Division of Vital Records, P.O. Box 68 for the Hospital or Attending Physician: The law requires that the death certification	igned by the attending p	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Y No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live Birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3 L	Ectopic pregnanc Other (specify)	У		23d. Date Mont			
P.O.	gned by se detac	by Ph	Part II. Other significant conditions of	contributing to death but not	resulting in the u	ınderlying cause giv	ven in Part I.		7.42	ute to the cause of death?		
ds,	been sig	ted	-					1 0 \		Probably 4 Unknown		
Division of Vital Records, alor Attending Physician: The law requires	s certificate has be director, page 2 sh	Completed						24a. Was a autop perfor	rmed? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No		
	ctor, p		25. Was case referred to medical examiner?			26. Pla	ace of Death (Chec					
: Si	this ce	유	1 Tes 2 No	Hospital: 1 Inpatient 2			4 K Nursing Ho		lence 6 🗆 Other			
on of	ath. r: After t	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio		28b. Time of injury	work'		28d. Describe h	ow injury occurred			
Divisi	s after de I Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe		eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,		
Hospita	within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check 2 Medical Exam	sician: To the best of my kn iner: On the basis of examina se Practitioner: To the best	ation and/or invest	tigation, in my opinio	on, death occurred a	t the time, date a	nd place, and due t	o the cause(s) and manner stated.		
To th	within To the comp		29b. Signature and title of certifier			29c. License	number		29d. Date signed (Month, Day, Year)		
			30. Name and address of person who	completed cause of death (I	tem 23a) (Type, F	Print) Tot	C Hon	ise 1	Ave 1	rederieh		
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Sig		1 100			/	M		
	Registra		DEC 0 1	2011 Jenua	B. A	racke						

11-08406 Joseph Pierce

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ph Pierce		1- For State	e of Maryla		rtment of		and Ment	al Hy	giene Reg.	2	011 3837
Physiciar lical Examin	1/	1. Decedent's Name (First, Middle, L	ast) James	P	erce				Date of Death Month November 9		3. Time of Death 0820 hrs
		4a. Facility Name (if not institution, Chester River Health Sy	give street and nu	mber)	1	b. City, Town Chestert	n, or Location of OWN			4c. County o	
Funeral Director	- 1		Sex	7. Age (In yrs. la	ast birthday) 3/ Yrs.	If Under 1 Months	Year If Under Days Hours	Min.	/ /	MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
La 19-10030 be filed within 72 hours after death with mital Hygiene. rked other than "natural", or items 23 ent, the Medical Examiner must be no	10 Be completed by Funeral Director	Usual Residence of Decedent 10a, State 10b, County PA 10e, County DeLau 10e, Street and Number 737 W. Brook 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce 15. Decedent's Education (Specify Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La Doseph 19a. Informant's Name (Relationship MeLisca Evers 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spec 21. Signature of Funeral Service Lice	12. Was Dec Armed For 1 Yes ed If Yes, Give Yea or Dates: College (1 st) Removal from the Armed For 1 Yes, Give Yea or Dates: College (1	Rd edent Ever in U.s proces? 2 No r de completed) 4 or 5+) CCC Dom State	16a. Decedend during mo	Sarcl 10f. Zip Cod 10f. Zip	f Hispanic Origination, Mexican, Mospecify: upation (Give kilfe, DO NOT to the literation) Its Mother's contract and Number of Community of Community (Community) Its Mother's contract and Number of Community (Community) Its Mother's contract and Nu	ind of wouse retired	rk done 16	White, Specify: L Sb. Kind of Bus PLu den Surname) Reco r, City or Town Ling Surce Oc. Education -	American Indian, Black, etc. White siness/Industry Long State, Zip Code) Long PA 19086 City or Town, State
the death certificate be executed which is a standing physician and ched for use as the burial - transit Diversity Medical Examiner	dical Examiner	or condition resulting in death)	each line. a. Heroin Due to (or as a b. Due to (or as a c. Due to (or as a d. AMENDED 4 23c. If yes, 6 1 Live b	Intoxic consequence of consequence o	ation):): 8a-f,pe		3922 12-		l sm	23d. Date of o	Between Onset and Death
certificate has been signed by the ector, page 2 should be detached	pe completed by	1 Yes 2 No 9 Unknor Part II. Other significant condition 25. Was case referred to medical examiner?	s contributing to	death but not re	sulting in the u	nderlying cau	ace of Death (0	Check on	1 Yes : 24a. Was an autopsy performe 1 Yes 2 y one)	2 No 3 24b. W pr de No 1	oute to the cause of death? Probably 4 Unknown Vere autopsy findings available for to completion of cause of eath? ✓ Yes 2 No
To the Hospital or Attending Physical within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification, 10	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date (Month, ation fd 11 28e. Place (Specify)	Day, Year) -9-11 e of Injury - At hore four t of my knowledge of examination an	28b. Time of Inf fd 7:17 me, farm, stree nd in he, death occurr	am 1 am ouse	Injury at Work? Yes 2 X I ce building, etc.	No U	or Town, State nesterto ue to the cause(s ne time, date and	et and Number 113 Fa 113 wn, Md. and manner a place, and du	d r or Rural Route Number, City irview Dr. as stated,
		30. Name and address of person wh		e of death (Item 2	•	0.	C.M.E.	Baltimo	N	lovember 1	
Stat Registra	~	31. Date filed (Mdr) Day Meal 2	327Re	gistrar's Signatur				-a:tii110	10, NID 2 122		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38379 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Movember Day 16 2011 7:39 Physician/ Harold Glen Pope Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days May 28. 1951 Hours West^(y)Virginia Months 217-58-3576 60 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 10a. State with the Maryland must be notified at Director 1 Tes 2 X No Knoxville Maryland | Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö items 23a Funeral United States 21758 245 Knoxville Road death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ō þ 1 Never Married 2 X Married Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Underground Utilities Supervisor other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental In Important: If item 27 is marked any injury or care Elsie Ruth Hodge 2 Wade H. Pope 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 245 Knoxville Road, Knoxville, Maryland 21758 Elsie Ruth Nichols / Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 21 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Frederick, Maryland Resthaven Memorial Gardens Keeney and states bastord PA Funeral Home, 21. Signature of Funeral Service License MO1473 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ preumonia disease or condition Medical resulting in death) e to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year for Pregnant at time of death ed by the a Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Impatient 2 ER/Outpatient 3 DOA 1 Yes ျှ within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar

completed

29a. Certifier

3 🗆

Jeff Kaninotimo

30. Name and address of person who completed cause of death (Item 23a) (Type,

29b. Signature and title of certifier

31. Date filed (Month DEC

DHMH 17 Rev 7/2009

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1certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29d. Date şigned (Month, Day, Year)

alesta

21701

Please Type or Print in Black Indeline Ink Fnsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Mont Day 2:00 PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Phillips Mill Road Forest Hil If Under 1 Year If Under 24 Hrs. 6. Sex 1 **X** M 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) (Month, Day, Hours Min Country) 90 214-10-0051 arvland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🕅 No Forest Hill Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2022 Phillips Mill Road 21050 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify White 3 Widowed 4 Divorced WW II Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College_(1-4 or 5+) Salesman Retail Furniture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry Harlan Pvle Sr. Bessie Susan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 19a. Informant's Name/Relationship (Type, Print) Beverly Francis (Daughter Phillips Mill Rd. Forest 20c. Location - City or Town, State MaryLand 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov Date 26. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛣 Other (Segret ombment Gar r Mem. 22. Name and Address of Facility . Signature of Euneral Service E.G. Kurtz & Son Funeral Jarrettsville Approximate Interval Between death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final munresulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last (or as a consequence of): yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Other (e

Physician/ Medical Examiner

attending physician and for use as the burial-transit

State Registrar

10a. State

MD.

Director

Funeral

Completed by

Be

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Physician/

Medical

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyghene. Important: If fire 27 is marked other than "network" any injury or other tweeners.

Examine Physician/Medical cate has been signed by the a page 2 should be detached f <u>۾</u> Completed l e 10 Certificate:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Director: After this certificate

within 24 hours a

To the Funeral C

completed filled

Medical

29a. Certifie

only or

30. Name and address of person who

31. Date filed (Month, Day, Year)

29b. Signature

funeral

ompleted cause of death (Item

32. Redistrar's

Division of Vital Records, P.O. Box 68760

1 ∐ Yes 2 ∐ No 9 ☐ Unknown	g 🗆 Unknown	
Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 Yes 2 No No Yes 2 No
25. Was case referred to medical	26. Place of Death (Ch	neck only one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 Residence 6 ☐ Other (Specify)
27. Manner of Death Natural 5 Pending Accident Investigat		28d. Describe how injury occurred
3 Suicide 6 Could no 4 Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of the knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MD R071959

BAKIMORE,

29d. Date signed (Month, Day, Year)

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State Registrar

Br

23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38381 State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ James Thomas Preston Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Western MD Regional Medical Center Cumber land If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7 Age (In vrs. last birthday) **Funeral** M 2 D F (Month, Day, Year) 01-14-1936 220-32-4687 Maryland **Director** Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director Frostburg MD Allegany 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 23a U.S.A. 21532 33 Hawthorne Drive items death 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No 1958
If Yes, Give 1961 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Medical Examiner Black White etc. i filed within 72 hours after de tal Hygiene. Id other than "natural", or it 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 1961 Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Market traumatic event, the Inventory Control Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental is marked o မ Charles M. Preston Mary S. Quinn Preston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a 2017 Orchard Ave. Jessup, MD 20794 daughter Roxine Noone 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o Frostburg Mem Park 1 Burial 2 Cremation 3 Removal from State 11-17-2011 Frostburg, MD Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sowers Funeral Home Alan M00547 60 W. Main Street Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death shock, or heart failure. List only one cause on the line. Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): anding physician and use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 L retailed.
Pregnant at time of death in the past 12 months? Month Year Dav g 🗌 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 0 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsv performed death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: the Hospital or Attending hin 24 hours after death. Natural 2 Accident injury work? 5 Pending 2 🗌 No I Director: A ed in by the f Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide upleted filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one 29b. Signature and title of 1)00 33280 NOV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lohnson Heights Blogs Suite WI Cumberland MD 21502 MD-

32. Registra's Signature

Please Type or Print in Black Indelible Ink. Ensure, All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1816P M Brenda Lee Rayfield Medical 4a Acility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** egiony Wedien C Wicomico reninswa If Under 1 Year If Under 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Months Davs Min (Month, Day, Year) Director 221-38-1350 1 🗆 M 2 🔀 F 58 Delaware Feb. 12, 1953 show 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 228 Wall Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+ Transportation 11 School Bus Driver permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Porches Evelyn Ada Bell (Husband) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Lee Rayfield, Salisbury, MD 21804 228 Wall Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Blades Cemetery Nov. 8, 2011 Blades, Delaware 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street 21. Signature of Funeral Service Licensee Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Ph_sician/ ANOXIE ENCEPHA 20THY Medical resulting in death) **Examiner** ARDIA Sequentially list conditions, if any, loading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consection as offand I-transit that the death certificate be executed Due to (or as a consequence of) burial-t resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE ase 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Year Day 1 Yes 2 No 4 ☐ Pregnant
9 ☐ Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à STACE BENAL DIREASE Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plunds DEPENDENT DIABETE MELLITY autopsy 24b. Were autopsy findings available autopsy prior to completion of cause of death? has page Yes 2 X N 1 Yes Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes No No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 No Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) of 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the f 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, de 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MD Dennis Chodnick 100 E. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 08 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38383 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROMOLO RASTELLI Novembe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Plata Conte La 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** (Month, Day, Year) Months Min 220-07-1013 1 2 M 2 🗆 F 91 Yrs. ITALY Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director MD. CHARLES LA PLATA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral or items 23a 105 HALDANE DRIVE 20646 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, th and Mental Hygiene. 27 is marked other than "natural", or iten traumatic event, the Medical Examiner I Black, White, etc. þ 1 Never Married 2 X Married 1X Yes 2 No If Yes, Give ARMY Baltimoré, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced WWII Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education Kind of Business/Industr (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DEPT. OF ŃAVY Elementary/Secondary (0-12) College (1-4 or 5+) U.S.GOVT. PROCUREMENT OFFICER 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ DOMINIC ANTONIO RASTELLI PASOUALINA DIVENTURA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. ANNA J. RASTELLI-SPOUSE 105 HALDANE DR. LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART CEM. 11-30-11 LA PLATA, MD. ☐ Donation 5 ☐ Other (Specify) M00479 21. Signature of Funeral Service Licensee Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 Part 1. Enter the disease, or complication wat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocard disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence on ir any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? j Month Day Year 1 Yes 2 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has autopsy performed e Hospital or Attending Physician: The I 24 hours after death. • Funeral Director: After this certificate h 2 🗌 No Yes 2 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be 2 Z No Other: 1 Yes ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 🔲 Yes 2 🗌 No 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pendina Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Purse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signatu State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 38384 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 19. 2011 2:35 p.M Dorothy Mav Medical 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Examiner Citizens Care and Rehab Center Frederick Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under **Funeral** Hours 233-30-2959 Usual Residence of Decede Director 1 □ M 2 💢 F 91 West Virginia 12/13/1919 or 28a-f show notified at with the Maryland 10a State 10b. County 10c City Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No MD Frederick Frederick 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be n Funeral 514 Military Road United States 21702 Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Associate Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Skeens Amber Eskew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Masser / daughter 5604 Drought Spring Ct., Frederick, MD 21702 Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/23/2011 Frederick, MD 4 Donation 5 Other (Specify) Olivet Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Basford Funeral Home sepulue Kre MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause area h line. Approximate Interval Between Bet and Death Immediate Cause (Final - hysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Natural Accident 5 Pending 1 Yes 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

the Hospital or Attending Physician: The law requires that the death certificate be hours after death. Ineral Director: After this certificate Certificate: To within 24 hours a Medical Certifying Physician: To the best of my knowledge, death oscurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examiner in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death of curred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Sign 29d. Date signed (Month. Day, Year) 30. Name and address of person who comp ted cause of death (Item 23a) (Type, Print) 9th St., Frederick, MD 21701 Robert Kaufmann 300 W. 31. Date filed (Month 32. Registrar's Signature State Registrar ORIGINAL

DHMH 17 Rev 06-2011

DY

Registrar DHMH 17 Rev 1/2001

State

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

73 . Registrar's Signature 29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\int\) 38386 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 6:25 P November 26 2019 Physician/ Fred Martin Rodda Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Examiner Frederick Frederick Memorial Hospital If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours 87 *d%/1*09%1**9**24 Pennsylvania Director 199-12-0181 Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hyglene. and I filew 27.5 is marked of other than "natural", or items 23a or 28a-f sho ury or orther traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No Frederick Frederick MD 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 21701 United States 6351 Spring Ridge Pkwy, Apt. 229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Was Decedent Ever in U Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates. WWII Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than ". Elementary/Seconday (0-12) College (1-4 or 5+) Auto Industry <u>Assembly Line Worker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Katherine Duckett Thomas Rodda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21701 6351 Spring Ridge Pkwy, Apt. 229, Frederick, MD Mary Alice Rodda / wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department o Important: If any injury or once. Smithsburg Crematory 11/28/2011 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service Licensee 106 E. Church St., Frederick, MD 21701 MO1222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** NEUMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed SEVERE and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed this certificate 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica sted filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending work? 2 🗆 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year, cause of death (Item 23a) (Type, Print) Name and address of person was . Registrar's Signat State Registrar

Dr

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38387 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 08:45 AM Menth 18 2011 Physician/ Edna M. Rohrer Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Westminster Emeritus at Summerville Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth '. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🛭 F 0572571924 87 Director 214-09-4123 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10b. County 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 No Westminster Carroll MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21157 45 Washington Road th and Mental Hygiene. 27 is marked other than "natural", or items: traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) T.W. Mather & Sons Sales 12 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Lottie A. Russell D. Anderson Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. 4779 Blue Hill Road, Glenville, PA Sheryl D. Reed/daughter 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Meadow Branch Cemet.: 11/21/2011 | Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final narenou Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence on attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year Month Pregnant at time of death 5 Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ☑ N 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death.

Ineral Director: After this
d filled in by the funeral di After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c, Injury at 28d. Describe how injury occurred Certificate: work?
1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined City or Town, State) vithin 24 hours a to the Funeral D ompleted filled i Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. thin the the 29d. Date signed (Month, Day, Year) 29c. License number 2 4 6 29b. Signature and title of certifie 11/18/2011 westmenster MD 2115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) washington Ka 31. Date filed (Month, Day, Year) NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 38388

		•	State Registrar		C	ertificate of D	Death	Re	g. No.			
	DI .	,	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death		
	Physicia Medic		George Ralph S	hank				November	r 14 20	Ď11 5:45 P M		
	Examin	er	4a. Facility Name (if not institution, give				Location of Death		4c. County of Death Washington			
فيميد			16612 Spiceberry 5. Social Security Number 6. Se		rs. last birthday		stown If Under 24 Hrs.	8. Date of Birth		9 Birthplace (State or Foreign		
	Funeral Director			YM 2 DE	83 Yrs.	Months Days	Hours Min.	Sept. 16		Country Maryland		
	and show at	ō	10a. State 10b. County	10c	. City, Town or l	_ocation				10d. Inside City Limits		
	Aaryla 8a-f : tified	rect	Maryland Washir	aton	Н	agerstown				1 ☐ Yes 2xxxNo		
	the had a or 2	<u>-</u>	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh			
	h with	Funeral Director	16612 Spiceberry Ct. Apt. A 21740 U									
	deat r iten iner r		11. Marital Status1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No	1951 13	. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		- American Indian, , White, etc.		
36	after al", o Exam	d b	3 ☐ Widowed 4 ☐ Divorced	1 Laryes 2 □ No If Yes, Give Year or Dates.		1 ☐ Yes 2 🗓 No	Specify:		Specify:	White		
Ö	hours natur lical I	lete	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dec	edent's Usual Occup	ation	king	16b. Kind of Bus	siness Industry		
21	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Mediral Examiner must be notified at	Completed by	Elementary/Seconday (0-12)	College (1-4 or 5+)	life.	DO NOT use retired) Groundskee	-	ung	Educ	cation		
121	d with tygier ther t nt, th	0	17. Father's Name (First, Middle, Last)			GLOUITUSKEE		ne (First, Middle, M		2462011		
Maryland 21215-0036	be filed ental Hy ked oth ic event	10	Benjamin K. Shar	ık			Grace	Hou				
ary	should and Me is mar raumati		19a. Informant's Name/Relationship (T)	pe, Print)	19b. Ma	iling Address (Street a	and Number or Ru	ral Route Number,	City or Town, Sta	ate, Zip Code) 21740		
Σ	and 2 s Health a tem 27 i		Charlotte V. Shar				erry Ct.			wn,Maryland		
ore	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗍	Damas Chata	cemetery, cr	position (Name of rematory or other place	e)			City or Town, State		
tim	20c. Location 20d. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donayon 5 Other (Specify) 21 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park 12 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park 13 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park 14 Donayon 5 Other (Specify) 25 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park 15 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park 16 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park 17 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park 18 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park 19 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park 19 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park 19 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park 19 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) 19 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) 19 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) 19 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) 19 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) 19 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) 19 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) 20 Signmure Superplace of Disposition (Name of cemetery, crematory or other place) 20 Signmure Superplace of Disposition (Name of cemetery, crem									21795		
Ba	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once.		2) Sign ure Funeral na		4	25 S. Cond	cocheagu	e St.Wil	liamspor	rt,Maryland		
			23a art 1. Enter the disease, or comp shock, or heart failure. List only or							Approximate Interval Between		
	Physician/		Immediate Cause (Final disease or condition	Metach	tie	Lung Ca.	neer			Onset and Death		
Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
		er	Sequentially list conditions, if any, leading to immediate	years.								
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or iinjury		,,-							
	tificate be executed ng physician and as the burial-transit	I Ex	that initiated events resulting in death) Last	Due to (or as a con	sequence of):	<u> </u>						
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687			IF FEMALE:	23c. If yes, outcome of pre	egnancy				224 Data	of deliver		
Box (ath ce attenc for us	cian	in the past 12 months:	23c. If yes, outcome of pre 1 Live Birth 2 4 4 Pregnant at time	Fetal death 3	Cother (specify)	У		Mont	e of delivery th Day Year		
Ö.	the de	Physician/	1 Yes 2 No 9 Unknown	9 Unknown								
<u>P</u>	s that gned k	by	Part II. Other significant conditions co	entributing to death but no	t resulting in the	e underlying cause giv	en in Part I.			bute to the cause of death?		
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CO	law re has be e 2 sh	Completed						24a. Was ar autops perforn	y pr	lere autopsy findings available rior to completion of cause of eath?		
æ	physician: The lav ir this certificate has eral director, page 2		OF Mary and an add an add and				(D. H. (Ot.	1 🗆 Yes 2		Yes 2 No		
lital	sician certif irecto	э Ве	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	0 □ EB/Outpot	_ Oth	er:	lome 5 Reside	non 6 🗆 Other	(Specify)		
of V	g Phy er this ieral d	e: To	27. Manner of Death	28a. Date of injury (Month, Day, Yea	28b. Time	of 28c. Injur	y at	28d. Describe ho				
OU	endin sath. or: Aft he fun	ficat	1 Netural 5 Pending 2 Accident Investigation		ii) iii)diy		Yes 2 No					
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendit completed filled in by the funeral director, page 2 should be detached for use	Certificate;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, secify)	street, factory, office		28f. Location (Str City or Town		r or Rural Route Number,		
Ω	spital hours neral d filled	ledical	29a. Certifier 1 Certifying Phys	ician: To the best of my k	nowledge, deat	h occured at the time	, date and place, a	Ind due to the caus	e(s) and manner	r as stated.		
	the Ho in 24 the Fu	Med	(Check 2 ☐ Medical Exami only one) 3 ☐ Certifying Nurs	ner: On the basis of examine Practioner: To the best	nation and/or inv of my knowledge	estigation, in my opinion, death occurred at the	on, death occurred e time, date and pla	ace, and due to the	cause(s) and man			
	with To To		29b. Signature an Utitle of certifier	W		29c. License	944996	2	od. Date signed	(Month, Day, Year)		
			30. Name and addiess of person who co	ompleted cause of death	(Item 23a) (Type	.Prigt)	La AMARA	11 11	Nonzel	15, 2011		
Ib	1-3+1		Cofar r	aniu M	0	01 511	ajjivi	is keep	1.50055			
	Stat	е	31. Date filed (Month, Day Year)	32. Registrar's S	ignature	bartel						

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		1- For State Registrar		Ce	rtificat	te of D	eath				Reg. No	_	<i>)</i> {	1 3030
Physici dical Exami	an/	Decedent's Name (First, Midd				C	L		2	2. Date of De Month Novemb		Year		3. Time of Death 1900 hrs
Tour Exami	1101	Robin 4a. Facility Name (if not institution	Ann on, give street and num	nber)			ith City, Town, or L	ocation of	Death	Novemb	4	lc. County of		
		1060 G. Noland Drive				Hagerstown				Washington				
Funeral		5. Social Security Number		7. Age (In yrs. I	ast birthd	Marchael David Harris Latin			1		i	Foreign	nplace (State or	
Director		212-80-1569	1 M 2 X F	45		Yrs.			1111	May	5, 1	966	Cou	ntry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or	Location		_						10d. Inside City Limits
*	ŗ	MD Washi	ngton	На	gerst	town							ŀ	1 X Yes 2 No
Maryland 28a-f show d at once	Director	10e. Street and Number			-	10	f. Zip Code				10g. Ci	itizen of Wha	at Coun	try?
ith the Maryland 23a or 28a-f show potified at once.	<u>a</u>	1060G Noland				21740				U.S.A.				
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fter de		3 Widowed 4 X Div	1 Yes	2 X No		1 Yes 2 No specify:				Specify:	Wh	ite		
215-0036 be filed within 72 hours af ntal Hygiene. rked other than "natural ent, the Medical Examin	ed by	15. Decedent's Education (Spe-	or Dates: cify only highest grade	e completed)			Isual Occupation							ndustry
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5-00% led within Hygiene.	Completed	9 17. Father's Name (First, Middle,	, Last)		Hom	emake		8.Mother's	Name (First, Middle		omesti n Surname)	.c	
21215 uld be file Mental Hy marked o	Be	Roger Smith						Alice	Jea	an Wit	mer			
→ 6 5 3 ±	욘	19a. Informant's Name/Relations		_			dress (Street					-		
and 2 s lealth ar tem 27 traum		Tracy Brown/Dat 20a. Method of Disposition	ighter	20b.			(Name of cem			lagers Date		. Location - 0		740 Town, State
Baltimore, permit. Pages I and Department of Heal Important: If tem injury or other tra		1 X Burial 2 Cremation		m State	crematory	or other	olace)	- 1	11/0	0/201	İ			
ltim uit. Pa artmen ortant		4 Donation 5 Other Sp 21. Signature of Funeral Service	pecify: Licensee	Re	St Ha		Cemeter and Address					lagers Tunera		
Dep Dem		S. Mark .	Sayo			1601	Pennsy	1van	ia A	ve.,	Hage	rstow	n, l	-
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.											Approximate Interval Between Onset and
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		Sequentially list conditions,	b	consequence o	1).									
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	consequence o	f):									
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eath ce	sici	1 Yes 2 No 9 V Unk	,	int at time of de vn	ath 5	Other	(Specify)				Ĩ			
that the d		Part II. Other significant conditi	ions contributing to	death but not r	esulting in	the unde	rlying cause giv	ven in Part	I.	23e. Did	tobacco	use contrib	ute to th	ne cause of death?
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Record The land	E									1 ✓ Yes	formed?		ath? ✔ Yes	2 No
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Dj spital nours a neral l	9	4 Homicide	mined (Specify)	-										
Division of To the Hopital or Attending Phenthin 24 hours after death. To the Funeral Director: After I completely filled in by the funeral	Medical	Check only	hysician: To the best miner:On the basis of											
To To com	Med	29b. Signature and title of certifie	and manner sta	ated.			29c. License	number			29d.	Date signed	Mont	h, Day, Year)
		D-14)-					O.C.M	I.E.	November 25, 2011					
		30. Name and address of person				000:::	5				4000			
N-0		Donna M. Vincenti, M.		edical Exan		900 W.	Baltimore S	street, E	saitimo	ore, MD 2	1223			. <u> </u>
St Regist		31. Date filed (Month, Day 1987)	12 8 20 20 Reg	Jistrars Signati		1	Selfer!							

DHMH 17 Rev 1/2001 OCME 2006

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 38390 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ MARN Medical 4c. County of Death Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death Examiner to mo Re en If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Country) 11^{(M}078-77927 89 MD **Director** 212-14-1068 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Talbot Bozman 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21612 7635 Cooper Point Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian rmed Forces?

X Yes 2 \(\sum \) No þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) wholesale foods warehouse supervisor permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important; If item 27 is marked other any injury or other traumatic event. H Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Charles P. Schisler Mabel Pillsbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7927 Bozman - Neavitt Rd Bozman MD 21612 Dianna Hambleton (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other pla Eastern Shore Cemetery 1 X Burial 2 Cremation 3 Removal from State MD 4 Donation 5 Other (Specify) 11-4-2011 Hurlock, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility, Fellows, Helfenbein & Newnam Funeral Home, P.A. MERC ERON 200 S. Harrison St <u>Easton MD 21601</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eumon, Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir sician and burial-transit Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death signed by the a d be detached f Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 s has certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 Inpatient 2 FR/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work?
1 \(\subseteq \text{Yes} \) Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗜 🤆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗍 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Typa, Print)

3+VA

State Registrar 31. Date filed (Month Pay, Year) 2011 32. Registrar's Signature

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38391 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month | 1 villard .Tho mas 16 2011 17:52 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Medical Center Baltimore 7. Age (In yrs. 80 If Under 1 Year If Under 24 Hrs. **Funeral** ial Security Number last birthday 8. Date of Birth 9. Birthplace (CLARTON 203-24-0340 1 X M 2 □ F Months Hours Director PENNSYLVANIA Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 Tes 2XX No MARYLAND CECIL NORTH EAST 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 187 RAZOR STRAP ROAD 21901 UNITED STATES 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or Dates US ARMY 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 OPERATING ENGINEER MARINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CHARLES F. STEWART HAZEL CONNOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH STEWART / SON 187 RAZOR STRAP ROAD, NORTH EAST, MARYLAND 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State NOVEMBER 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MAYERDALE CREMATORY 20, 2011 NEWARK, DELAWARE 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Immediate Cause (Final Onset and Death Filysician/ uamous disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month sate has been signed by the page 2 should be detached g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director. After this certificate h completed filled in by the funeral director, page performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature

Registrar

State

30. Name and address of person who completed cause of de

31. Date filed Wonth, Day, Year

MD

10

N.

32. Registrar's Signature

ath (Item 23a) (Type, Print)

greene

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 10:55 P M Josephine Sterling 2011 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Salisbury Wicomico Wicomico Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours New York 055-10-1993 95 Director /16/1915 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director notified Maryland Wicomico Salisbury 1 Yes 2 X No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be 23a Funeral 21801 USA 1110 Healthway Drive items ; death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ☐ Yes 2 X No "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medianone. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 corporate officer/chartist Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sephine Jacob Planz Josephine Kaiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Creekside Dr., Salisbury, MD 21804 W. Jerome Sterling III/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Wicomico Memorial
Park 1 X Burial 2 Cremation 3 Removal from State 11/9/2011 Salisbury, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown the page 2 should be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vonknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed death? 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to dical Be 26. Place of Death (Check only one) examiner? Other 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Monner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending **Natural** 1 🗌 Yes 2 \square No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STE 21804 Salisbury, MD 910 Easternshore Dr. <u>Mahesha</u> Thimmarayappa M.D

DHMH 17 Rev 7/2009

State

Registrar

NOV 0.8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38393 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 12, 2011 Physician/ 1:20 a M Evelyn Scott Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Co. Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 225-56-4939 71 Director 1 □ M 2 🔏 F 02-04-1940 Virginia Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Completed by Funeral Director 28a-f Charles Bryans Rd 1 X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 20616 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene. 5435 Sir Douglas Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Never Married 2X Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify Black Yes, Give 3 Divorced 4 Divorced Year or Dates. er than "nature, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accounting GAO Building 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Connie Cashwell th and Mental H 27 is marked of traumatic ever ည Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 5435 Sir Douglas Dr. Bryans Rd., MD 20616 item 27 other tra Levon Scott/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date of t ± 5 1X Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. Heritage Memorial Pk | 11-19-2011 Waldorf, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH Signature of Juneral Service Licensee 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Pancreatic Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 as the IF FEMALE: asn yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 month
1 Yes 2 XNo Month Day Year 5 Other (specify) Pregnant at time of death ed by the at detached for 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? certificate filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2X No 1 Yes မ 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending e Hospital or Attendi 124 hours after death. e Funeral Director; A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medicafi Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D70395 11-15-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Farah Abdulsalam

31. Date filed (Month, Day, Year)

1500 Forest Glen Rd. Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38394 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NÖVEMBER 18 2011 RUBEN CLIFTON SANDERS 10:10 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Cecil Laurelwood Care Center 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** Months Days Hours 1 M 2 🗆 F Feb 24 1926 Maryland 85 Director 214-20-3463 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f sho per must be notified at filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No MD Cecil Earleville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 Hilltop Dr. 21919 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Black, White, etc. 0 þ 1 ☐ Never Married 2X Married 1 X Yes 2 No Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. Specify: "natural" Completed 3 Widowed 4 Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Automobile al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Manufacturing Assembly Lineworker 6 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any in]ury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ William George Sanders Mabel Rhoades 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Emma May Sanders (wife) 100 Hilltop Dr. Earleville, MD. 21919 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 11/22/11 4 Donation 5 Other (Specify) Zion Cemetery Cecilton, MD. 22. Name and Address of Facility
Galena Funeral Home of Stephen L.
118 West Cross St. Galena, MD. 21 su of Fy M00510 or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. 1 1. Enter Approximate interval Between Onset and Death Immediate Gause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): dispuse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 Pregnant
9 Unknown 5 Other (specify) Pregnant at time of death been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To this . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of the funeral 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury work? 1 🔲 Yes Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D0026183 Nov. 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madhu S. Sachdev, M.D. 322 E. Cecil Ave., North East, MD. 21901 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Division of Vital Records, P.O. Box 68760, After this certificate has been signed by funeral director, page 2 should be detach After this al or Attend after death Director: To the Hospital within 24 hours a To the Funeral I

1 ☐Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature analytitle of certifie

person who completed cause of death (Item 23a) (Type, Print)
A LIAV 1205 CORT 30. Name and address of

ROAD Registrar's Signature 31. Date filed (Month) Pay Year 32. State

Medical

10

DIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G922 12/15/2011 JH State of Maryland / Department of Health and Mental Hygiene 20 | 38396 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2011 2:37 P^{M} Stewart November Patty Jane Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Washington 1129 W. Washington St. Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1 - M 2 X F Months Days Hours Min. July 5, Country) Michigan 60 Director 219-58-6000 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location Director 1 X Yes 2 No MD Hagerstown Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21740 U.S.A. 1129 W. Washington St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black White etc. 1 ☐ Yes 2 🔀 No If Yes, Give by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Painter Carpentry e 1 and 2 should be filed wi of Health and Mental Hygis fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ပ Jack Llewellyn, Sr. Virginia R. Andrews 1915, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410319a. Informant's Name/Relationship (Type, Print) 4158 Winfield Way, Westminster, MD Jack Llewellyn, Jr./Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If it any injury or of once. 1 Durial 2 X Cremation 3 Removal from State Smithsburg Crematory 11/29/2011 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Funeral Chapel 22. Name and Address of Facility 21. Signature of Funeral Service Licensee S.Ma 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Obstruct Chromic Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence or) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Hospital or Attending Physician: The law requires that the death of thours after death. 24 hours after death. Funeral Director: After this certificate has been signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, examiner? Other: 4 Nursing Home Hospital 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of trijury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Vithin 2 only one 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) 28 2011 D0021285 address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown N Walny State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38397 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 16, 2011 12:15PM LENA ELLEN STOGDON Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Country 1 □ M 2√ F 14/1919 213-20-4738 92 Director Usual Residence of Decedent 23a or 28a-f shov 10a. State 10h Count 10c. City. Town or Location 10d. Inside City Limits at Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified Whiteford MD Harford 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21160 1502A Dooley Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No $5/1 \neq /1919$ 000 = 11/16/2011 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White 3√Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary L. Williams Mary L. ၉ George W. Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. 1502 Dooley Road, Whiteford, MD 21160 Robert A. Bostic/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Conowingo Bap.Cem 11/19/11 Conowingo, MD 21. Signature of Fundral Service 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA Kober 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Neumoni disease or condition resulting in death) Medical to or as a consequence of **Examiner** Sequentially list conditions, Examine Due to lorus a consequence of if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury and that initiated events Due to (or as a consequence of): resulting in death) Last physician at the burial-Physician/Medical as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Month Year Pregnant at time of death the 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown is been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Myeloma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy performed death? 2 🗌 No 2 🔽 No 1 Tes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined e Funeral L 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 170 0059855

State Registrar

190

: M 80033604

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland 7 Department of Health and Mental Hygiene 2011 38398 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Dale Beverly Sipes Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumber1and Western MarylandRegional Medical Ctr. 5. Social Security Number 216 – 25 – 5525 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MD **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2X No MDAllegany Little Orleans 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe Funeral USA 10954 High Germany Road 21766 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 X Married 2 should be filed within 72 hours a.c. th and Mental Hyglene.

27 is marked other than "natural", o Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) National Park Service Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Chief of Mantenance 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic Irvin Asbury Sipes Clara Belle Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10954 High Germany Road Little Orleans, MD 21766 Helen M. Sipes/Wife Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 11/19/2011 Martin Cemetery Little Orleans, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street M00260 P.A. Hancock, MD 21750-0368 Grove Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ assive de disease or condition Medical resulting in death) Due to Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and as a conse attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown P.O. Part II. Other, significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 3 Probably 4 Unknown No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No certificate has page 2 1 Yes 2 No the Hospital or Attending Physician: '19 24 hours after death.

Funeral Director. After this certification of fleted filled in by the funeral director, I 25. as case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ဂ္ 1 Yes 2 NO 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of Certificate: 1 Natural 28c. Injury at work? 28d. Describe how injury occurred iniury 5 Pending 1 Yes 2 🗆 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Withii To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Can

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Nagaratnam A.Ranjithan, MD 12500 Willowbrook RD Cumberland, MD 21502

Registra Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar 38399 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11 Physician/ 2011 09:25 AM Chester Calvin Stalev Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick 4886 Blue Spruce Lane Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Y Hours Min Year) Country) 218-34-3514 1 X M 2 D F Director 82 10 1929 Maryland Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location by Funeral Director notified Frederick 1 X Yes 2 No MD Frederick 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code items 23a or ner must be n 'n 21703 4886 Blue Spruce Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. "natural", or iter edical Examiner Armed Forces?

1 XYes 2 No Black, White, etc. Page 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify. Specify: If Yes Give Completed 3 Widowed 4 XDivorced Year or Dates al Hygiene. d other than "natur: went, the Medical E 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Flooring Technician 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Flooring Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked of r other traumatic ever Chester Stover Leona Catherine Staley မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 244 West Side Ave., Hagerstown, MD 21740 19a. Informant's Name/Relationship (Type, Print) Chester Staley Jr./ Son altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State - : ხ Rest Haven Memorial Garden 11/23/11 Frederick Department of Important: If any injury or 4 Donation 5 Other (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home Signature of Funeral Service Licensee 106 E. Church St., Frederick MD 21701 MØ1646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Pregnant at time of death signed by the at If be detached for Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed?
Yes 2 1 Yes mpletely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After tí 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

"Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) within 29b. Signature and title of cer

State Registrar

31. Date filed (Month, Day, Year,

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov 9 Dorothy Scheible 11:38 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death n/a 5906 A Glen Falls Avenue Baltimore 8. Date of Birth (Month, Day, Year) Oct 31, 1925 9. Birthplace (State or Foreign Country) OH Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min Director 220-16-7087 1 M 2 DXF 86 28a-f show aţ 10a, State 10c. City, Town or Location 10d. Inside City Limits Director nit. Page 1 and 2 should be filed within 72 hours after death with the Maryla hardrment of Health and Mental Hyglene. ortant: I fitem 27 is marked other than "natural", or items 23a or 28a-f si njury or other traumatic event, the Medical Examiner must be notified. MD Baltimore n/a 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5906 A Glen Falls Avenue 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces's Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) machinist American Can Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Orpha Ellen Lee DuVall Wilbur S. Benson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 34 Fullerton Hghts. Ave.Apt. A Baltimore MD **Dorothy Bees** daughtel **Baltimore** MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. cemetery, crematory or other place)
Oliver Grove Cemetery 1 X Burial 2 Cremation 3 Removal from State 11/13/2011 Oldtown MD Donation 5 C Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA LFuneral Service Licensee ignature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyperlipidemia 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific e of death (Item 23a) (Type, Print) Belair Rd Batt,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 25, per me, g922 12-14-11 sm
State of Maryland / Department of Health and Mental Hygiene For State Registrar 38401 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Physician/ Rosemary Thiel 1745 2011 November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Memoria F ASTON HOSPITAL TALLOT If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) 193-38-9593 63 1 🗆 M 2 🛣 F **Director** 8-4-1948 PA "natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 No Talbot MD St. Michaels 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 24700 Deep Water Pt Rd 21663 Roseman 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meones. life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) General Manager Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edmund Martin Trene Mee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Thiel (Husband) 24700 Deep Water Pt Rd Easton MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Chesapeake Cremation 11-3-2011 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A.
200 S. Harrison St Easton MD 21601 MERC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRA CEREBRAL Physician/ HEMORRHAGE disease or condition Medical resulting in death) Due to (or as a consequence of): EXAMINER Examiner TION APPROVED BY AMED Sequentially list conditions, Examine Digit to for as a nonsectionne of If any, leading to trainedist cause. Enter Underlying the burial-transit Cause (Disease or injury that initiated events and CERTIFIC Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? certificate 1 Yes 2 No Vital To the Hospital or Attending Physician: 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 1 Impatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) of 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Division M 2 Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Get trying Prijorcian. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gettifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Praneto D0066441 NOVEMBER 2nd 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21601 washington ST, Easton MD Kolli, Ramesin 2195 31. Date filed (Month, Day, Year) NOV 0 4 2011 Registrar's Signature State Registrar

Thie

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 24a per med cert 6922 12797 All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 38402 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** 3:11pM Martha P. Tull November 02 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Princess Anne If Under 1 Year | If Under 24 Hi Somers Living of ManoKIN Autora Sr. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🛛 F 4-16-1921 MD 219-14-2978 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 28a-f show event, the Medical Examinar must be notified at 1 □ Yes 2 DNNo Director Pocomoke Worcester MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 21851 USA Funeral 2262 Groton Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 □Yes 2 XNo Specify If Yes, Give Year or Dates: SpecB:lack ò 3X Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Campbell Soup Co. 12 Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Corbin Jones Unk ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S of Health 2262 Groton Road, Pocomoke, MD 21851 Alonzo Tull/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o Marial 2 ☐ Cremation 3 ☐ Removal from State 11-8-2011 Pocomoke, MD 4 Donation 5 ☐ Other (Specify) Zion UM Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebovasadan a cuident **Physician** on week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 54 cars alnal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner 5 years requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy 1 ☐Yes 2 No 26. Place of Death (Check only one) funeral director. 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending 1 ☐Yes 2 ☐ No investigation al or Attend s after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide To the Hospital within 24 hours a To the Funeral I Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier maka Net November 3rd 2011 705135 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415. S. DIVISION ST SFLISBURY MD 21804 NATESAN USHA 32. registrar's Signatur 31. Date filed (Month, Day, Year) State NOV 07 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 Zakai Thomas Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death HICOMICO REGIONAL MEDICAL 586156419 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country) Director 1X M 2 | F 1 Oct 25,2011 MD Usual Residence of Deceden 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f shor Examiner must be notified at Director MD Wicomico Salisbury 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 726 Dennis street 21801 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates. n/a 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian n/a Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African-1 Yes 2 XNo Specify. "natural", Completed 3 Widowed 4 Divorced American other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) marked other than Elementary/Şecondary (0-12) College (1-4 or 5+) n/a n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Zadok Thomas RaLanda Rowley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 1 and 2 s of Health a item 27 i RaLanda Rowley/mother 726 Dennis Street, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ■ Burial 2 □ Cremation 3 □ Removal from State
 □ Donation 5 □ Other (Specify) Tindley Chapel Cem 11/04/2011 Pocomoke City, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, 1618 West Rd., Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each, line Immediate Cause (Final Physician/ membanes disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death ed by the a detached 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 🗡 No 1 Yes 25. Was case referred to medical examiner? **Division of Vital** Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital 2 4 No Other: 1 Yes 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D54997 10-25-2011 and address of person who completed cause of death (Item 23a) (Type, Print) 5A4156W4 100 E. CATION St. EVANS M.0

State Registrar 32. Registrar's Signature

			For State Registrar	ct)		Certificate of L	Death	_	Reg. No.		0.77	
	Physicia		Decedent's Name (First, Middle, La.	David Alan	Tesch			2. Date of De Month Novembe		OT1	3. Time of 0	Death PM
	Medic Examin		4a. Facility Name (if not institution, give		100011	4b. City, Town, o	r Location of Death		4c. County			
and a	/		Union Hospital 5. Social Security Number 6.8	17.0	and the second second	E1kto	n I If Under 24 Hrs.	To 5 1 (5)	Ced			F
	Funeral Director			Sex 7. Age (In) 83	yrs. last birthd Yr:	Months Days	Hours Min.	8. Date of Bir (Month, Da June 15		_ Count	lace (State or try) Consin	Foreign
	and show dat	tor	10a. State 10b. County	100	c. City, Town o	r Location				1	0d. Inside City	/ Limits
	Maryl. 28a-f otifie	Director	Maryland Cecil		E1kto	on					1 🗆 Yes	2 X No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral D	10e. Street and Number 1032 Elk Forest	Road		10f. Zip Code 2192	1		10g. Citizen of V	What Coun		
ယ္	er death or item miner n	by Fur	11. Marital Status 1 □ Never Married 2 【X Married	12. Was Decedent Ever i Armed Forces? 10 1 X Yes 2 No	70	13. Was Decedent of H If Yes, specify Cuba		pecify Yes or No- o Rican, etc.)		e - America ck, White, e		
003	ursaftuural", ural", al Exan	ted t	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give 19 Year or Dates.	52	1 ☐ Yes 2 🗓 No	Specify:		Specify:	WII-	ite	
Maryland 21215-0036	72 hou .n "nat Medica	Completed	15. Decedent's E (Specify only highest gr	rade completed)	(G	ecedent's Usual Occup live kind of work done o e. DO NOT use retired)		king	16b, Kind of B	usiness Inc ed Sta	-	
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and	e filed Ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	, ,		9)		
12	ould by market market		Willard J. Tesch		10b N	ailing Address (Street		N. Bullo		State Zin C	ade)	
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Baltimore,	of He of He or othe	1	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐		0b. Place of D	isposition (Name of crematory or other plac	e) Nove	Date ember	20c. Location -	· City or To	wn, State	
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Ba	Depar Depar Impo any ir		21. Signature of Funeral Service Licen:	See ()			Stockton					
			23a. Part L Enter the disease, or com shock, or heart failure. List only of	aplications that caused the	death. Do not	enter the mode of dyin	g, such as cardiac	or respiratory an	rest,		Approximate Interval Betw	veen
	Prysician	2 1	Immediate Cause (Final disease or condition		LUVASC	ULAR AL	LIVENT			- 7/1	Onset and Do	
	Medical		resulting in death)	Due to (or as a cor	the consumption							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38405 State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 for State Registrar Certificate of Death 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month | Day 1 0560 M Physician/ Helen Bertha WEGNER 4c. County of Death Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Washington Hagerstown 16914 Alcott Road 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Ye March 21 If Under 1 Year If Under 7. Age (In yrs. last birthday, Social Security Number Days Hours Min. 1918 Pennsylvania **Funeral** 1 - M 2 X F 93 Director 169-05-7999 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a, State of Health and Mental Hygiene. "Health and Keep or terms 23a or 28a-f shoother traumatic event, the Mental Examiner must be notified at other traumatic event, the Mental Examiner must be notified at **Funeral Director** 1 Yes 2 X No Sharpsburg Washington Maryland | 10g. Citizen of What Country? 10e. Street and Number 21782 16745 Taylors Landing Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Mental Examiner musonce. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. 11. Marital Status 1 Never Married 2 Married þ Specify: 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 3 X Widowed 4 Divorced Completed 16b Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Store Secretary 18. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, Middle, Last) Bertha Frederick Lindewirth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16914 Alcott Road, Hagerstown, Maryland 21740 Sandra Burd - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Hagerstown, Maryland Hagerstown Crematory 11/19/2011 4 Donation 5 Other (Specify) Minnich Funeral Home Signature of Funeral Service 22. Name and Address of Facility 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Karken Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rabble Physician/ disease or condition Du to (or as a consequence of) Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Vear Month Live Birth 2 L Fetal deat
Pregnant at time of death in the past 12 months?

1 Yes No Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes No 3 Probably 4 Unknown ۾ Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 26. Place of Death (Check only one) 25. Was case referred to medical eral Director: After this certification of the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 Z No 28d. Describe how injury occurred 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death injury 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direct Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praydone: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completed 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar Fernsylvana

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1000

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sarah Harmon Warner $\mathbf{a}^{\,\text{M}}$ 2011 1:30 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury 425 Robinson Street If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Min. Director 212-16-7281 1 M 2 XF 91 Vrs 10/24/1920 Maryland Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director r 28a-f sh notified 1 Yes 2 X No Maryland Wicomico Salisbury 10e, Street and Numbe 10f, Zip Code 10g, Citizen of What Country? ò ms 23a or must be r Funeral 425 Robinson Street 21801 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or iter edical Examiner Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Black Completed 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Health Care Nursing Assistant Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I .. Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o ည Pearl Whitney Samuel Dryden Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Robinson St., Salisbury, MD 21801 Pearl Harmon/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State Quantico, MD Head-O-Creek Cemetery 11/12/2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Etewart Tuneral Home by Holloway and Downey,P.A. 821 West Rd., Salisbury, MD 21801 Kell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final CV Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury tran that initiated events resulting in death) Last Due to (or as a consequence of): as the burialattending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregn. 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Yes Unknown g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, 27. Manger of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No s after death.

I Director: At Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined building, etc. (Specify) City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 029/05 Uddleston NI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STE 106 Milford St., Suite 103, Salisbury, MD 21804 Christjon Huddleston, M.D. Registrar's Signature

Registrar DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Jnk. Ensure All Copies Are Legible.

Amend Item 26 per DVR GJZ. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 | | | 38408 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11717772011 3:35 p^{M} Vera Odene Worley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Boonsboro Charlotte's Home Social Security Number . Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Hours 2 1 24 7 1 9 24 Tennessee 87 **Director** 235-34-8158 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State with the Maryland Director 1 Yes 2 ☐ No Hagerstown MD Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 U.S.A. 20512 Beaver Creek Road 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced White Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than, Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 <u>Supervisor of Supply</u> U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Willie George Yarworth William Keel traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is n 20512 Beaver Creek Road, Hagerstown, MD 21742 Mary Jane Perini / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Druid Ridge Cemetery 11/25/2011 | Baltimore, Maryland 21. Signature di Funeral Service 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIAC DYSCHTHMIR disease or condition Medical resulting in death) Examiner CARDIOVASCULAR Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Y PEKTENSION that the death certificate be executed and -trans Due to (or as a consequence of) resulting in death) Last burial physician the burial Physician/Medical NON INSULIN Division of Vital Records, P.O. Box 68760 attending physics are as the IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Month ☐ Pregnant at time of death ☐ Unknown the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC KIDNEY DISCASE, Left Nephrector 1 Yes 2 No 3 Probably 4 Unknown RHEUMATOID VASCULITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas performed certificate POTHYROIDISM Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Asst. Living examiner? 2 No Other: 4 \square Nursing Home 5 Residence 6 X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA မြ in 24 hours after death.

the Funeral Director; After this impleted filled in by the funeral directed the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled in by the funeral directed filled 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title 11-18-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A IN DECIUE HD /622 Camelot B Falling Waters, WV. BLUD 31. Date filed (Month, Day, Year)

State Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Mar	yland / De	partment o	f Healt	th and Me	ntal Hyg	iene 20		38410
	_		Registrar 1. Decedent's Name (First, Middle, Last)		ertificate o	Deat		. Date of Dear	th		3. Time of Death
	Physicia Medic		Theodore A. Wylie						er ^D ¶y0, 2	Őľ1	1815 Р м
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town				4c. County o		
1	Funeral		Surburban Hospital 5. Social Security Number 6. Sex 7. Age (III	n yrs. last birthday			ider 24 Hrs. 8.	Date of Birth	1		lace (State or Foreign
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	land show d at	or		0c. City, Town or	Location		1 100	CL. 24	, 1940		0d. Inside City Limits
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	ems 2	une	5721 Grosvenor Lane 11. Marital Status 12. Was Decedent Ever	r in U.S.	3. Was Decedent of	0814 of Hispanic	Origin? (Specify	Yes or No-	Unite		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.		If Yes, specify O	uban, Mex	ican, Puerto Ric	an, etc.)		, White, e	etc.
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	37,		30. Name and addre	ess of person who	completed cause of d	eath (Item	1 23a) (Ty	pe, Print)	ine	Ave.	Salizb	ru/s	, and	2180	4
	Stat Registra	100	31. Date filed (Monti	h, Day, Year)	2011 32.1 Sistra	ar's Signat	ture	Bar	lad			(5		25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NOVEMBER MARCENE WIEWECK 2011 11:00A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Days Hours Minnesota 09/28/1923 **Director** 88 474-14-7680 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MN Hutchinson McLeod 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1015 Centure Ave., SW, Apt. 55350 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White Completed 3 X Widowed 4 Divorced Specify. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygier is marked other t 12 Homemaker Own home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arthur Carl Dobberstein Johanna Bertelsen of Health and Me of Health and Me if item 27 is mark rother traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Schnaser / daughter 144 Monterey Street, Poinciana, Fla. 34759 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Pauls Lutheran Cem. 11/30/11 Stewart, MN 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home elle Kre MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Htheroscleroti disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence oi). Examir The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death signed by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 1 Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 \square No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at eral Director: After filled in by the funer 28d. Describe how injury occurred 1 X Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi

State Registrar

DIC

me and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:30 A M 2011 11 21 Donald Atlee Workman /Medical 4b. City, Town, or Location of Death LaVale 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 65 LaVale Court Allegany If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) (In vrs. last birthday) **Funeral** 1 M 2□ F 89 219-14-5104 **Director** 05 1922 Maryland 10 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, in a Medical Examinar must be in tiffied 1 ☐ Yes 2 No LaVale Directo MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 U.S. 4. Funeral 65 LaVale Court 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1943 Irres, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 "natural", or I 1 □Yes 2 No <u>S</u> 3 Widowed 4 Divorced Year or Dates: White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 4 College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Workman Elsie Hott Workman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health a 65 LaVale Court LaVale, MD 21502 wife permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr Betty Workman 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-26-2011 Frostburg, MD Frostburg Mem Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home. 60 W. Main Street Frostburg, MD 21532 MOQ547 Man Jower 3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** THREE MONTH IVER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ■ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 MNo 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **5**000 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number DO033417 (MARRIMO) NOVEMBER 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUEN MD 1068 NATIONAL HIGHWAY LAVALE, MOTHELAND MMES 12 31. Date filed (Month, Day, Year)

DEC 0 1 2011 32. Fegistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

11-08585 Craig Lee Whyte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2011	3841
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ang Lee Willyte		1- For State CF Wallyland 7 Dep	ertificate o			_	eg. No.	
Physicia	an/	Decedent's Name (First, Middle,Last)				Date of Deat Month		3. Time of Death
edical Exami	ner	Craig Lee Whyte		4) 0'1	-1tion of D	Month November	15, 2011 4c. County of Dea	1306 hrs
		Facility Name (if not institution, give street and number) Se46 Buckeystown Pike		4b. City, Town, o	or Location of D	eatn	Frederick	tn
Funeral			s. last birthday)	If Under 1 Ye	ar If Under 2	4Hrs. 8. Date of Bir		irthplace (State or
Director		442-80-3058 1X M 2 F 39	Yr	Months Da	ys Hours	December December	15, 1971 Fore	country) Kingdom
*ny		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Loca	tion				10d. Inside City Limits
E	_	Maryland Frederick		Fı	rederick			1 Yes 2 X No
Maryland 28a-f show d at once.	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Co	untry?
r death with the Maryland or items 23s or 28s-f shor must be notified at once.		9551 Kingston Place			21701		Jnited States	
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er dea		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year		Yes 2 X N	lo specify:		Specify:	#hite
urs aft rtural'	d by	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	nt's Usual Occup	ation (Give kind		16b. Kind of Busines	s/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked ofter than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 5+	,	nost of working lit School Tea		e retired)	Educatio	n l
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D 27 should and Me	P	19a. Informant's Name/Relationship (Type, Print) Kristin Jeanne Whyte / Spouse	1.1	,			nber, City or Town, Sta	te, Zip Code)
and 2 sho ealth and tem 27 is traumati			b. Place of Dispo	sition (Name of c	emetery,	Date	yland 21701 20c. Location - City	or Town, State
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Baltimore, permit. Pages I an Department of Hea Important: If ite		4 Donation 5 Other Specify: 21. Signatur of Fun al Service Lipinsee				A. Funeral I		, iziryzwas
E E E			01433 10	06 East Ch	urch Str	eet, Frederi	ck, Maryland	
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Divinal of ours at ceral Diffilled i	Certification:	4 Homicide determined (Specify) Hotel/Mo				5646 Buckeys	stown Pike, Frederic	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Runeral Directors. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination	ledge, death occi n and/or investiga	urred at the time, ation, in my opini	date and place on, death occur	e, and due to the caus rred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
To Wit	Mec	29b. Signature and title of certifier		29c. Lice	nse number		29d. Date signed (A	fonth, Day, Year)
(00)	5)	Alle Brassell Me	\rightarrow	0.0	C.M.E.		November 16,	2011
		30. Name and address of person who completed cause of death (Ite		A/ Dalkies -	Strant Dall	imara MD 2421	23	
		Melissa Brassell, MD Assistant Medical Exam 31. Date filed (Month, Dan 1841)			otreet, Balt	umore, MD 2122	دی	
S Reais	tate	31. Date filed (Month, Danov 3 0 20 33 Registar's Signa	J. J.	gare				

Richard M Williams, Sr.

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State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certific	ate of Death	Reg. N	lo.	
Physici		1. Decedent's Name (First, Middle, I	.ast)		Date of Death Month Da	y Year	3. Time of Death
[#] ∽dical Exami	ner	RICHARD M	12) ILIAMS SR	•	November 17	, 2011	1803 hrs
		4a. Facility Name (if not institution,	give street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death	
		1127 Bradley Road		Pasadena		Anne Arundel	
e	-	Social Security Number 6.	Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24H	rs. 8. Date of Birth(M	IM/DD/YYYY) 9. Bir	thplace (State or
Funeral Director				Months Days Hours Mi		Foreig	ın j
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		Usual Residence of Decedent					
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Maryland 28a-f show datonce,	용	10e. Street and Number	710.000	. 10f. Zip Code	10g. (Citizen of What Cour	ntry?
or 28	Director	1107 0	1 0-	01100		1 1 6 1	
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deat or ite	.5	1 Never Married 2 Marr	1 Yes 2 No				1
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5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin		15. Decedent's Education (Specific		Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		b. Kind of Business/I	ndustry
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Ing Ph After t funeral	Ë	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	Time of Injury 28c. Injury at Work?	28d. Describe how	injury occurred	
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risior r Attend er death rector:	2	2 Accident Investig	28e Place of Injury - At home f	arm, street, factory, office building, etc.			ıral Route Number, City
Divis ospital or A hours after neral Dire y filled in b	힢	determ			or Town, State)	
fil ou		4 Homicide 29a. Certifier A Continue Physics		eath occurred at the time, date and place, an	nd due to the causo(s)	and manner as etat	ed
he H in 24 he F	Sa		ner:On the basis of examination and/or	investigation, in my opinion, death occurred	at the time, date and	place, and due to th	e cause(s)
To the Hos within 24 h To the Fur completely	Medical		and manner stated.			d. Date signed (Mo	
	Σ	29b. Signature and title of certifier	4	29c. License number		- '	
		Samely with	all mi)	O.C.M.E.	l N	lovember 18, 20	ווע
		30. Name and address of person w	no completed cause of death (Item 23a)				
		Pamela E. Southall, MD		er 900 W. Baltimore Street, Bal	timore, MD 2122	23	
	tate		32. legistrar's Signatur				
S Regis		RFC 0 1	2019 Gensua B.	barles			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ 7:50 AM Ruth Smith Zeender 2011 November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4030 Hamilton Street Prince George's Hyattsville Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)

vember 2, 1 🗆 M 2 🕱 F 021-18-7852 Months Davs Hours Director 90 Concord, MA November Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4030 Hamilton Street 20781 USA death 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married by hours after Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: "natural". Specify: White 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 72 (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Seconday (0-12) College (1-4 or 5+) University of Maryland Librarian 4+ marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 Thomas J. Smith Alice F. Jeffrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Mark Zeender / Son 4030 Hamilton Street, Hyattsville, MD 20781 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) injury or 11/21/2011 Washington, DC 4 Donation 5 Other (Specify) Mount Olivet Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue 'n Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Confisss 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phytician Myocardial Infarction Hours disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Myocardial Ischemia Hours Sequentially list conditions, if any Lading to immediate cause. Enter Underlying Examir Cause (Disease or linjury that initiated events Atherosclerotic Cardiovascular Disease Years Due to (or as a consequence of): resulting in death) Last burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 phys: IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Hypertension, Paroxymal Atrial Fibrillation, Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Dyslipidemia, Chronic Renal Insufficiency 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No page Dementia 1 Yes 2 No nours after death.

neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🗷 Residence 6 🗆 Other (Specify) 2 X No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 \(\subseteq Yes \(2 \subseteq \) No 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Hospital Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif Hovember 16,2011 6510 Kenilusth Acc, #2600 Riverdale MD 20737 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 10 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) November 12, 201er Physician/ 6:40 Рм Joan Marylyn Batting Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie 102 Crain Hwy N; Apt 857 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number **Funeral** 088-24-4782 **Director** 1 M 2 X Feb 17, 1930 New York 81 or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County with the Maryland Director 1 Tes 2 No Anne Arundel Brooklyn Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ō must be r USA Funeral 21225 310 16th Avenue items? filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status "natural", or ite Black, White, etc. Armed Forces 1 ☐ Yes 2 🛛 No If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates. COSE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) bookkeeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vivian Wilhelmina Kopf မ Joseph Thomas Manucia Page 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $310\ 16th\ Avenue\ Brooklyn\ Park,\ MD \ 21225$ 19a. Informant's Name/Relationship (Type, Print) Department of Health as Important: If item 27 is any injury or other trau Robert L. Faber/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State State Anatomy Board 655 W. Baltimore Street 21, Signat MD Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last physician by Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for t in the past 12 months? Pregnant at time of death 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Yes 2 □ No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No n 24 hours after death.

Funeral Director: Ai
bletely filled in by the fu Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 within 2 To the F 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of

32. Registrar's Signature

7445 FURNACE BRANCH Rd Glen Bringth Hole

death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ase Type or Pr							-			jible		
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		Registrar 1. Decedent's Name	e (First, Middle	e, Last)		007	incai	001 2	Catif		2. Date of De				3. Time of	Death
Physicia Medio		Ionathar									Month Novemb		ay 21 , 2	2011	4:17	AM ^M
Examin	er	4a. Facility Name (if	not institution	n, give street and number)			1		Location o			4	c. County			
Funeral		Dove Ho 5. Social Security No		6. Sex 7. A	ge (In yrs. Ia	ast birthday)	If Unde	r 1 Year	inste	24 Hrs.	8. Date of Bi	irth		arro 9. Bir	thplace (State or	<i>Foreig</i> n
Director		215-19-4		1 💢 M 2 🗆 F	27	Yrs.	Months	Days	Hours	Min.	June 2	24 Year)	1984	Má	Tryland	
ind show at	5	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	cation						-		10d. Inside Cit	y Limits
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hould and Me is mar		19a. Informant's Na	ame/Relations	1 1 2 1		19b. Mailir	ng Addres	s (Street a	n <i>d Numb</i> e	r or Rura	A Route Numbersville	er, City o	r Town,	State, Zi	ip Code)	
ind 2 s lealth a m 27 i				ce/spouse					rive	Syke	sville	, MD	21	/84		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.			☐ Cremation	3 Removal from Stat		Place of Dispo emetery, crer			9)	[Date	20c. i	_ocation	- City o	Town, State	
mit. Pa bartme bortan / injury		4 🛛 Donation 21. Signature of Eur	neral Service L	1///	ector	. 26	Name a	nd,Addres	s of Facilit	Roar	a 655 W	J R	21+i1	nore	Street	
Depar Impor any in		/100	w	MULL		- P	alti	more,	MD_	212	01		4101			
		shock or hear	of failure. List of	r complications that cause only one cause on each li	ed the deat	h. Do not ente	er the mod	de of dying		(Approximate Interval Betw Onset and D	veen
Physician/ Medical		Immediate Cause (I disease or condition resulting in death)		Due to (or as		SA F	11		M	ele	lul	· · ·	2		Oriset and D	eatti
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eath certificate be attending physicie	ician	23b. Was decedent in the past 12 r 1 Yes 2	months?	1 Live Birth	2 Feta	al death 3	Ectopic Other (s	pregnancy pec <i>ify)</i>	y				23d. Da Mo	ite of de onth		′ear
that the deaned by the a detached	Phys	9 🗌 Unknown		9 Unknown												
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Physi rthis c eral din	e: 10	1 Yes 2 2 27. Manner of Death	∆No h	1 ☐ Inpa		ER/Outpatier		OA Othe 28c. Injury	4 ∐ Nu		me 5 Res 28d. Describe		_		WOLF	7(5
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or Atte ifter de Directo in by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	inod 28e. Place of Ir	jury - At ho tc. <i>(Specify</i>		et, factor	y, office			28f. Location (City or To			er or Ru	ıral Route Numb	er,
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completed filled in by the funeral		29a. Certifier 1	Certifying	Physician: To the best of	of my knowl	ledge, death (occured a	the time,	date and p	olace, an	d due to the ca	ause(s) a	ind mann	er as st	ated.	
the Ho hin 24 I the Fu npleted	Medical	only one) 3	Certifying	Examiner: On the basis of Nurse Practioner: To th												ner stated.
Vith To		29b. Signature and t	title of certifier	o Kints	CV	w	29	License	number	7 2					h, Day, Year)	
		30. Name and addre	ess of person	who completed cause of	death (liter)	1 23a) (Type, F	Print)	- / -	20	10						
		Def.	Klu	who completed cause of) (ente	/5	t. U	1451	m1	NSTE	R, N	UD	3	1157	
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OCME 2006

Registrar DHMH 17 Rev 1/2001

State

Carol Allan, MD

31. Date filed (Month, Day, Year)

32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

State

Registrar

MD 3001 Honouer St. Baltimore, MD, 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

02

2011

32. Registrar' Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38421 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Harry Paul Byrne Physician/ ^{Day}6, 2011 November 6:30 p M Medical 4a. Facility Name (if not institution, give street and number) Brook Grove Nursing & Rehab 4b. City, Town, or Location of Death OIney Examiner 4c. County of Death Montgomery Age (In yrs. last birthday) Funeral 5. Social Security Numbe 171 – 07 – 70116. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Months Days 1 X M 2 □ F Hours 7/19/1918 Director Yrs PA Usual Residence of Decedent 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 KNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20905 Funeral 17206 Emerson Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 SpecWhite If Yes, Give Year or Dates 1 Yes 2XXNo Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 4 Engineer Engineering Be 17. Father's Name (First, Middle, Last)
Harry J. Byrne 18. Mother's Name (First, Middle, Maiden Surname)
Mary A. Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17206 Emerson Dr. Silver Spring, MD 20905 Ruth Arlene Burton, stepdtr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other placel ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Uniformed Svcs. Univ. 11/29/2011 Bethesda, MD 4 X Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Service Licensee N 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cellulitis leg disease or condition davs Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uisease or injury that initiated events Due to (or as a consequence of): requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a the burial-t Physician/Medical Box 68760 IF FEMALE: use yes, outcome of pregnancy

Live Birth 2 Petal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Po Month Day Year signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has to completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🛛 Natural 5 Pending injury work?
1 Yes 2 No Division Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D0055694 11/28/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Months Day) Year) - > "

Alok Mathur, MD; 4000 Olney-Laytonsville Rd Olney, MD 20832

32. Signature

For State Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

38422

3. Time of Death

Birthplace (State or Foreign Country)

Baltimore, Maryland

14. Race - American Indian,

White

Black, White, etc.

23d. Date of delivery

Luite 405, Barkinere, MD 21204

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

pice

10d. Inside City Limits

Interval Between Onset and Death

1 Yes XXNo

7:45 AM

Registrar DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 8:30 A November 28. 2011 Brian Patrick Best Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Marriottsville Howard 2326 Adam David Way Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year, **Funeral Director** 213-50-3263
Usual Residence of Decedent Jun 21, 1959 1 **№** M 2 🗆 F Maryland 52 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No MD Howard Marriottsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō Funeral or items 23a 21104 USA 2326 Adam David Way death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Force Black, White, etc. 1 Never Married 2X Married ☐ Yes 2 X No ş Maryland 21215-0036 hours after 1 ☐ Yes 2X No Specify. If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4 or 5+) Sign Company Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Should be filer of and Mental H is marked ot Elise Gibson Thomas Oliver Best 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a : If item 27 is 2326 Adam David Way Marriottsville, MD 21104 Rhonda D. Best/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 11/30/11 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 6 months Adenocarcinoma of Lung Stage IV disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Medical death certificate be Box 68760 as the l IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ę Month Dav Year Pregnant at time of death 1 Yes 2 No g Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 8 1X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2X No 1 Yes 2 No 25. Was case referred to medical Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5X Residence 6 \square Other (Specify) Hospital 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ë Natural
Accident
Suici work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending injury Certificat Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 29, 2011 D30573 YVO ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad 10710 Charter Dr. Jon K. #G020 Columbia, MD 21044 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 105 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MACS VATTSVILLE CE OEOREE Age (In yrs. last birthday If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 Months Days Hours Min. Washington **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location with the Maryland must be notified at 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1308 Pennsylvania Avenue, SE 20003 U.S.A. items (Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black Completed 3 X Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working other than " Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Government 2vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ပ Hutchins Hedgeman Lena Norman Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 1308 Pennsylvania Avenue, SE Washington, DC 20003 Patricia Fisher -Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 11-28-2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature A Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II Funeral Home Korrold 10583 Middleport Lane, White Plains, Md. 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a cons ience of the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) should be detached g Unknown Unknown g signed by Part II. **Other significant conditions** contributing to death, but hot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 3 Probably 4 Unknown 1 Yes Be Completed this certificate has been ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death' perform 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Assisted Other: 2 2 🗆 🗤 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) Living 27. Manner of Deatl 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar title of certifie Š 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 5 THICOM 7

State

Registrar

31. Date filed (Month, Day, Year) **DEC 0 2 2011**

Registrar's Signature

		For	S	tate of	Marylan		artment of F		Mental Hy	giene)			
		1 - State Registrar				Ce	rtificate of	Death		Reg. No	201		38	425
Physicia	ın	1. Decedent's Name (First, Mid	dle, Last)	0					2. Date of Do Month	eath Day	y Yea	ar	3. Time of	
/Medic	al 🎸	Shirley	<u>H.</u>		eba	C/2			Novem		29 20		7:15	ρ ^M
Examin	er	4a. Facility Name (If not institut			,			r Location of Deat	h		County of D			
Funeral		Manor Care 5. Social Security Number	Heal 6. Sex			last birthday)	TOWSO If Under 1 Year	n If Under 24 Hrs	8. Date of Bi	rth	altim		ce (State or	Foreign
Director		216-52-5424	1 □ M	2 X F	82	Yrs.	Months Days	Hours Min.	(Month, D.			Country 2	y)	o o o o
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death with the Maryland ms 23a or 28a-f show r must be notified at	ř	10a. State 10b. Coun	,		10c. Cit	ty, Town or Le	ocation					100	 Inside Cit 1 ☐ Yes 	·
the M 28a-f	Director	Maryland Ba	ltimor	е	Wh	ite Ma	rsh 10f. Zip Code			10- 09	izon of Miles	Countr		
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after or ite		1 Never Married 2 M	arried	Armed Force			If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)		Black, W	hite, et	c.	
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shour ind M i mar umat	-	19a. Informant's Name/Relatio				19b. Maili	ng Address (Street					e, Zip C	ode)	
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es 1 a of He of He fitem		20a. Method of Disposition 1 □ Burial 2 🌣 Cremation				Place of Disponentery, cre	osition (Name of matory or other place		Date		ocation - City	~		
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permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er once.		21. Signature of Funeral Service	e Licensee	5 /	1		2. Name and Addre	ki Funer	al Home	PA				
	-	23a. Part1. Enter the disease, shock, or heart failure.	or complicati	ons to the	sed the deat	// /	1/07 014	Catam	71700110	Tacac	ex, Mar	-	and 27	
Dhusisian		shock, or heart failure. Li Immediate Cause (Final	st only one c	- 6			tor the mode of dyn	g, cuon do curdia	o or respiratory a	arrest,		- 1	nterval Betw Onset and D	veen
Physician /Medical		disease or condition resulting in death)	a		Men as a conseq	1 10						-	da	4
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) b. —	Due to (or	as a conseq	uence of):								
The law requires that the death certificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C											
oe execian a		resulting in death) cast	B.	Due to (or	as a conseq	uence of):								
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w requires that the d been signed by the should be detached	ysi	1 □ Yes 2 ☒No 9 □ Unknown		9□Unknow		Journ 92	_ (apcon))							
s that ned b e deta		Part II. Other significant condi	itions contrib	uting to deat	h but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco ι	ise contribute	e to the	cause of de	ath?
quire an sig uld be	ed by	Hyperte	m (10) N					10	Yes 2	□ No 3 □] Probat	oly 4 U	nknown
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stan: ertifica ctor, I	Be	25. Was case referred to medic examiner?	cal					26. Place of Dea	ath (Check only				1	
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or A after of Direct in by	Certification:	4 ☐ Homicide deter	rmined 2	building	etc. (Specif	y)	reet, factory, office		28f. Location (City or To			Rural F	Route Numb	er,
spital ours neral filled		29a. Certifier 1 Certify	/ing Physicia	an: To the be	est of my kno	wledge, deat	h occurred at the tir	ne, date and place	and due to the	cause(s)	and manner	r as stai	ed	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director.	edical	(Check only one) Medic	al Examiner:	On the basi and manner	s of examina	ation and/or in	vestigation, in my o	pinion, death occ	urred at the time	, date and	d place, and	due to t	he cause(s)	
To th To th	Me	29b. Signature and title of certif	ier		4-		29c. License	e number		29d. Dat	te signed (Mo	onth, Da	ay, Year)	
		KURLHELD	F	Hen	dina	1	D59	283		Nov	em he	r 2	0 7	511
10		30. Name and address of perso	on who compl	eted cause o	of death (Item	23a) (Type,	Print)				_ ,, ,,,,,,,,	1 -	- 1	- 11
V-		Richard O.	Aggo	M.C	84	15 B	ellong L	ane # 2	16, TOV	VSDI	MD	2	1204	<u> </u>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38426 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month when ber 15 2311 Verna R. Bata Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral 1**45-42**-**6792 1 □ M 2 □X Months Hours June 26, 1932 **Director** North Carolina Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits rector Md Anne Arundel Pasadena 1 Yes 2X No Ö 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with th Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the Medical Examiner must be a once. Funeral IISA 21122 610 Eliot Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedon. _ Armed Forces? 1 Yes 2 XNo Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 ★ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ಲ John Henry Pierce III Myrtle C. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50 Lake Tahoe Circle Bear, Del. 19701 Sister Vada B. Locklear Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State Midway Baptist Ch. Cem 11-22-2011 North Carolina 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, Inc. . Signature of Funeral Service Licensee 2 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause peach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Newhonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death sbeen signed by the should be detached g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 2 2 No 1 🗌 Yes ☐ Yes 25. Was case referred to dical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 🖾 Natural injury 5 Pending 24 hours after death. Funeral Director: A Investigation 2 Accident
3 Suicide the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 2011 Vember 30. Name and address of person who completed cause of death (Item 23a/Type, Print) JEOVAL 31. Date filed (Month, Day, Registrar's Sign Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ DWMAN ACQUELYN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie 202 St. James Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Min 195-24-0032 **Director** 1 M 2 F 80 11/28/2011 Pennsylvania Usual Residence of Deceden 28a-f shov 10b. County 10c. City, Town or Location aţ 10a. State 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2X No Glen Burnie Anne Arundel MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21061 St. James Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. "natural", Specify: White Completed 3 - Widowed 4 - Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natumy njury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) H&R Block Tax Preparer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Evelyn Haas Albert H. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 St. James Drive, Glen Burnie, Maryland 21061 Edward G. Bowman 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State Maryland Veterans Cemetery 12/5/11 Crownsville, MD 4 Donation 5 Other (Specify) re of Foreral Ser 21. Signa ce License 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home 421 Crain Hwy S.E., Glen Burnie, Maryland 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir sician and burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Pregnant at time of death g Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 No Yes 2 -N Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 2 100 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practicoper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of ce 29c. License number 2011

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State

DEC 0.2 2011

Name and address of

31. Date filed (Month, Day, Year)

1CHAEZ

Registrar's Signature

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who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Nov 26 2011 6:30 P Barnes George 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. FutureCare North Point Baltimore Co. If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 212-26-2251 1 XM 2 □ F Yrs. Dec. 4,1928 Maryland Usual Residence of Deceder 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 X No Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 Oakleigh Beach Road 21222 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify. 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Years Diesel Mechanic Long Shoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lily Muir James Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary L. Barnes (Wife) 905 Oakleigh Beach Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Glen Haven Cemetery 11/30/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death

work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Tes

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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Physician. Medical Examiner

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

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items 23a

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death

72 hours after

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

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attending physician and I for use as the burial-transit signed by certificate has blirector, page 2 s Be မ this funeral Certificate: 4 hours after death. •uneral Director: Aftely filled in by the fur

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 ☐ Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💯 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗀 Yes ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗆 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of

State

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Natural Accident

4 Homicide

29a. Certifier (Check

29b. Signature a

30. Name and a

31. Date filed (Mo.

Suicide

5 Pending

ktitle of certifier

Investigation Could not be

determined

181

ress of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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Medical

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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral D	10e. Street and Number 325 F Street,	NE		10f. Zip Code 20 (002		Og. Citizen of What Co United Sta	
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Records, P.O.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Medical Certificate: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of 1	of pregnancy 2 Fetal death 3 time of death 5 ut not resulting in the sent 2 ER/Outpati y Year) 28b. Time injury ry - At home, farm, s (Specify) my knowledge, death amination and/or invenest of my knowledge ath (Item 23a) (Type, nestown Ro	26. Pla 26. Pla 27. Pla 28c. Injury work? M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ce of Death (Check 4 X Nursing Ho at Yes 2 \sum No date and place, and time, dath occurred at time, date and place number	1 🗓 Yes 24a. Was an autopsy perform 1 Yes 2 conly one) me 5 Resider 28d. Describe how 28f. Location (Stre. City or Town, d due to the cause the time, date and e, and due to the c	Month acco use contribute to s 2 \(\) No 3 \(\) P P death? Acco use contribute to s 2 \(\) No 3 \(\) P P death? Acco death? Acco 6 \(\) Other (Spectral Injury occurred acco 4 injury occurred acco 6 \(\) Other (Spectral Injury occurred acco 4 injury occurred acco 6 \(\) Other (Spectral Injury occurred acco 6 \(\) Other (Spectral Injury occurred acco use contribute to a prior to a contribute occurred acco use contribute to a contribute to a contribute occurred acco use contribute to a co	Day Year I the cause of death? I topably 4 Unknown I topsy findings available completion of cause of I 2 No If y) I all Route Number, I ted. I bause(s) and manner stated. I bay, Year) I 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jeannette K. Barrett November 20 TT 08:35 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Charlestown Nursing Home Catonsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth **Funeral** Months Days Hours **Director** 219-20-9787 95 05/07/1916 Usual Residence of Decedent shov 10a. State 10b. County 10c. City. Town or Location with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🎇 No Maryland Paltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 709 Maiden Choice Lane 114 South 21228 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Healthcare permit, Page 1 and 2 should be filed with Department of Health and Mental Hygier Important; If item 27 is marked other to any injury or other traumatic event, the Once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ignatius Krasniewski Ludwika Smolinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2915 Sarasota Court Ellicott City, Maryland 21042 Dr. William H. Barrett, Jr. Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 □ Cremation 3 □ Removal from State Holy Rosary Cemetery 11/30/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 23. Part . Enter the disease of shock, or heart failure. List of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 20US Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the burial-tran ed by the attending physician and detached for use as the bunal-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autonsy Yes 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Division Accident Investigation after death Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) within 24 hours a
To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Continuing Number Practice of T. Inc. of the property of the following Number 2 and the cause of the first of the following Number 2 and the cause of the first of the following Number 2 and the cause of the first of the following Number 2 and the first of the following Number 2 and the first of the (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P30989 November 27 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 711 Maiden Choice In Catonsville MD 21228 MD 32. Registrar's Signature Registrar

agrinate

Barratt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marie Jeanette December Clay 2011 7:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Nottingham 68 Surrey Lane If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 79 213-28-9399 1 □ M 2XX **Director** January 28, 1932 Baltimore, Maryland Usual Residence of Decedent 28a-f shov 10d Inside City Limits 10a. State 10h Count 10c. City, Town or Location Director Examiner must be notified Maryland Baltimore Nottingham 1 Tes 2 X No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21236 68 Surrey Lane United States death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: White Specify: Completed XXWidowed 4 □ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Homecare 12 Caregiver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ျ Michael Paul Prodoehl Catherine Bernadine Holden 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code)
3 Hamill Road, Baltimore, MD 21210 Kathryn Bordone-Daughter and 2 s Health a item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o ō Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park Dec. 6, 2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Cemetery 22 Name and Address of Facility Evans Funeral Chacel and Cremation Services— 8900 Harford Road, Parkville, Maryland 21234 Signature of Funeral Service Licenses Parkville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) mesh Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to for as a consequence of If dry, leading to harred cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c, If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the Unknown or Attending Physician: The law requires that the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed be should be det by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed: has e 2 page 1 ☐ Yes 2 X No Division of Vital rector, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2**X** No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify this 27, Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ieral Director: After filled in by the funer injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined nin 24 hours a the Funeral D npletely filled Hospital Medical 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2, To the F complet 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 29c. License number Dec 2 2011 9 d cause of death (Item 23a) (Type, Print) Blue, 5601 Lock Kreven Rettimore MD 21239

State Registrar 1. Date filed (Month, Day, Year)

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#5,11,12,15,17-19b PERINF,2/17/2012, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Wally Coberg Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gioneral Hospital Baltimore o. Social Securi 220–52– If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk Age (In vrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) **Funeral** Hours Min. Days Director 1 🏿 M 2 🗆 F Apr 30, 1948 63 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho ampiniury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1723 Bolton Street 3rd flr 21217 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? unk Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-00 ${rak 36}$ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white 3 🗌 Widowed 4 🗌 Divorced Completed Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk မ Wallace H. Coberg Sr. Ada I. Hunt 19a. Informant's Name/Relationship (Type, Print)

Donald E. Coherg (Brother)

MD General Hospital Mailing Address (Street and Number or Rural Route Number, City or Town, State, 312 Stonewall in Fall ston 1997 21292 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state Ronald S. Wast State and Address of Facility ard 655 W. Baltimore Street MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Eequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine bue to (or as a consequence of): b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Property After this certificate has been signed by the attending physician and burial-tra Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Should 24b. Were autopsy findings available 24a. Was an page 2 s autopsy prior to completion of cause of death? performed

1 Yes 2 1 Yes 2 No 25. Was case referred to medical examiner?
1 1 Yes 2 No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) 11/18 2011

Registrar

State

address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signatu

Jubbs

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WYEMBER 182011 Alice M. Cromwell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death ACTIMORE WASHINGTON MEDICAL ANNB CENTER GLEN BURNIE Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Hours Oct 5 Kentucky Director 213-68-6909 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Linthicum Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 806 S. Campmeade Road 21090 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ⚠ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No Specify: white 3 Divorced 4 Divorced 44-46 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. timore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosie Myrtle Laprado Robert Lenzy Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Cromwell Jr/son 248 Glen Court Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) f Funeral S Rona Signatu State Anatomy Board 655 W. Baltimore Street in Baltimore. MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ck, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 🗌 Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death the 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has be funeral director, page 2 s performed? 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Michael Carroll Cook 6:48 November Medical 4c. County of Death Facility Name (if not institution, give street and number) **Examiner** tion of Death HARLES MEDICA ENIER 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral Director** 561-84-5236 1**X** M 2 □ F Yrs. 59 Oct 23, 1952 California Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f MD Charles Waldorf 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 2880 Brunston Castle Lane 20601 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 ☐ No If Yes, Give Year or Dates. 1975–78 Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced and Mental Hygiene. is marked other than "natural aumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Mechanic Building Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Aaron Cook Bonnie Bernice England 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Wendy Johnston/ Daughter 2880 Brunston Castle Lane Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/02/11 Woodbine, MD 21. Signatur of Funeral Se 22. Name and Address of Facility Sing Home Cremation Service P.O. Box 784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Heckrotte, P.A. clarksville, MD 21029 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Schenic Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last inding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death detached been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♥ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗌 No Yes 2 🔼 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 102 Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 9

Registrar

State

w; wes-p

M.

carrie M.

31. Date filed (Month Day, Year)-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11655

agovr:

D0050883

pL

11/30/11

captala MD 20646

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 2011 ichael 9 Jovember Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore The Johns Hopkins Hospital Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min 215-74-8036 02/27/1958 **Director** 1**X** M 2 □ F 53 Maryland ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Rosedale 1 ☐ Yes 2X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 2:)6 Potomac Avenue 21237 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Year or Dates. ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 12 should be filed within 72 in alth and Mental Hygiene.
n 27 is marked other than "r (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mason Tender Foreman Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Martin Clark Pauline Grace Cunningham other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Virginia Ellen Clark (Wife) 206 Potomac Avenue, Baltimore, Maryland 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 12/03/2011 Baltimore, Maryland gnature Funeral Salice Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Fastern Avenue, Essex, Maryland Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between nediate Cause (Final Onset and Death Physician metastati sease or condition Cance Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Exam and -trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy perform death? certificate 2 No 2 🗌 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 🗹 No Other: 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After if filled in by the funer 1 Natural 5 Pending work? 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) KES-000 November 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N Wolfe St Baltimore MD Hallowe 25 31. Date filed (Month, Day, Year 32. Registrar's Signatur State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0400 AM therine October 201 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Agnes Baltimore Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🕱 F 0 Yrs NONE Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Mary Ridge Drive and Mental Hygiene. 21133 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1. Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Mexican 1 Yes 2 No Completed by Itispanic 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental ပ္ rancisco 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Randallstown, MD esenia 20b. Place of Disposition (Name of cemetery, crematory or other place)

NEW CATHERAL

CEMETERS 20c. Location - City or Town, State Pages 1 20a. Method of Disposition Burial 2 Cremation 3 P BALTIMORE, MARYLAND 22. Name and Address of Facility SAINT AGINES HOSPITHL 21. Signature of Funeral Service Licensee 900 CATON AVENUE BALTIMORE, MARYLAND 2/229 per De advantorg 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 59 minutes Immediate Cause (Final **Physician** extreme disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an he law autopsy performed? Yes 2 No of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 📉 Ño Certification: To 2 ER/Outpatient 3 DOA After this 27. Mapner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 □Yes 2 □No investigation Director: Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral D certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of October 29, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Baltimore, MD- 21229 900 S. Caton Andrade

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ overnber Day Charles W. Carroll 1554 Medical 4a. Facility Name (if not institution, give street and number Examiner Ab City, Town, or Location of Death 4c. County of Death General maryland altimore Baltimore City 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Hours Aug. 17, 218-18-3242 87 Director 1924 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 7869 Leymar Rd. 21060 United States 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. Completed by 1 Never Married 2 X Married XYes 1 Yes 2 X No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced WW II Year or Dates. White or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Defense Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles W. Carroll, Sr. Lillian Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy B. Carroll / Wife 7869 Leymar Dr., Glen Burnie, Maryland 21060 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Crownsville MD Vet. 2011 4 □ Donation 5 □ Other (Specify) Cem. Crownsville, Maryland 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, 21. Signa Runeral Service Lice see 0 MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Ronie Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 2 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and Alle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NOV 2011 BRIAN MARK 6:54 A^{M} CRIMY, SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner WRNMMC** MONTGOMERY BETHESDA Social Security Number If Unde g. Birthplace (State or Foreign 8. Date of Birth Age (In yrs. last birthday) Funeral Days 1 2 M 2 D F Months Hours Min November 21, 1974 Mary Land 37 215-94-3312 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 🏝 No Clarksburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20871 United States 23319 Robin Song Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married à Maryland 21215-0036 hours after White 1 ☐ Yes 2 No Specify Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 should be filed within 7 and Mental Hygiene.
7 is marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Law Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, MioDe Saint Sorname) Barbara Ann DiGirolmo Wayne E. Crimy, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 23319 Robin Song Drive, Clarksburg, Maryland 20871 Jennifer Fan/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ecember 1. 2011 Montgomery crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 Donation 5 Other (Specify) Crematorium 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Rockville; Maryland 20850 Montgomery Avenue 21. Signature of Funeral Service Licensee Zo M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a 1 L Yes 2 L 9 L Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy page performed? death? certificate 1 XYes 2 □ No 1 ☐ Yes 2 🔀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2X No 1 Yes 은 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this c 1 🔀 Inpatient 2 🗆 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: XNatural
Accident
Suicide injury 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat certifie 29c. License number 29d. Date signed (Month, Day, Year) 25NW 2011 0101233230 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V BRADLEY ARTHUR SERWER, MD LCDR USN WRNMMC, BETHESDA, MD 20889 5600 32. Registrar's S State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Romeo Ferrer De Vera a.k.a.Rodrigo De Vera 9:40 A Nov. 28, 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson 1f Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day Year) Jan 29, Months Hours Min. 58 1953 Philippines Director 212-41-1813 1 X M 2 🗆 F Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No Baltimore Cockeysville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 United States 6 Staghorn Ct 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces? Black, White, etc. "natural", or ģ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Yes Give 3 ☐ Widowed 4 ☐ Divorced Asian Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Machine Operator Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of Cresencio De Vera Sr. Conchita Ferrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5030 Clifford Road Perry Hall, MD 21128 Benjamin De Vera /Brother Important: If item 27 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec 01 20c. Location - City or Town, State Department of 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 2011 Signature of Funeral Service License MO1585 22. Na Orematicon Famili Funeral Alternatives Melbec 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) METASTATIC COLON CANCER YPAR Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ been signer should be c HYPERTENSION Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 Yes Yes or Attending Physician: funeral director, 25. Was case referred to me of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 HOSACO 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 \(\subseteq \text{Yes} \) 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending Division 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ChAMES STREET BALTIMORE MOZI who completed cause of death (Item 23a) (Type, Print) 10V ANKROMMO 6701

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rena Dickman Month November 1.25 A 2011 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE@NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) MD Hours 08/16/1918 217-69-6875 Director 1 □ M 2 💢 F 93 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD N/A **BALTIMORE** 1 X Yes 2 No ò 10e Street and Number ms 23a or 10g. Citizen of What Country? Funeral 7218 PARK HEIGHTS AVENUE, #116 21208 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2 X No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 'natural", WHITE Completed 3XX Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed, Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other than injury or other traumatic. HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **JOSEPH** KRIEGER **FANNIE** MARX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANN OIDICK/DAUGHTER 32 DIAMOND CREST COURT, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State ANSTEE CHAIM AHther place) 12/01/2011 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service SOL LEVINSON & BROS., 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Atherosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) J physician ar resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending property for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Month Year 9 Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital 4 Nursing Home 5 Residence 6 Other (Specify) Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of After 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death. 2 Accident
3 Suicide 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

U ShajapaheM.D

N. S. Rajapakst,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

DHMH 17 Rev 06-2011

2835

32. Registra's Signature

29c. License number

170057465

203

29d. Date signed (Month, Day, Year)

11/30/11

Baltimore MD 21209.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38442 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6:10A _M NOVEMBER 29, 2011 Physician/ MARY A. EMBARDINO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Min Hours Director 323-12-1258 1 □ M 2 🗶 F 87 ILLINOIS DEC. 10,1923 ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 Funeral 4000 BALFERN AVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2X No Baltimore, Maryland 21215-0036 hours after Specify: WHITE 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced If Yes, Give "natural", Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Mont. Important: If item 27 is marked any injury or other. AGNES PIKULKA ANTHONY WESOLOWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PERRY HALL, MD 21236 ROSE STEVENS-DAUGHTER LONA COURT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/2/11 BALTIMORE, MD PARKWOOD CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME 9705 BELAIR RD NOTTINGHAM, MD 21236 Im 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final VENTRICULAR FIBRILLATION Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ISCHEMIC CARDIOMYOPATHY Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) CORONARY ARTERY DISEASE requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as t nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown ther significant conditions contributing to death but not resulting in the underlying cause given in Part I CHRONIC KIDNEY DISEASE STAGE 4 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy page performed?
1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \square Yes Hospital: 2 **X**No Other: ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? s after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29c. License number 29d. Date signed (Month. Day, Year) D37254 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON LIM, M.D. 7601 OSLER DRIVE TOWSON, MD 21204 31. Date filed (Month, Day, Year) DEC 0 2 2011 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38443 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUDITH NOVEMBER 8:05 PM M FOSTER 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice of the Chesapeake Anne Arundel Linthicum Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Months Days 1 M 2 X F Hours Min 284-36-6256 Director 70 Cleveland, OH 1941 April Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director FL St. Lucie Port St. Lucie 1 ☐ Yes 2 To No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 637 NW Whitfield Way 34986 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: "natural", 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) uld be filed with...
d Mental Hygiene...
d other than "r
the Me 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic ever ည should be James B. Crawford Sr. Helen Orzech .t. Page 1 and 2 shou...
-t of Health and Me
-m 27 is my 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 637 NW Whitfield Way Port St. Lucie, FL 34986 Robert N. Foster - Husband other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If it any injury or o cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 12-3-11 Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Cleveland, OH Funeral Service Lice see 22. Name and Address of Facility 21. Signature Golutski Funeral Home 5986 Ridge Road Parma, Ohio 44129 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part Approximate or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examine Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in listed ever in the cause) Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Day Year 5 Other (specify) ☐ Pregnant at time of death☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Completed 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🔀 Unknown GERD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No eral Director: After this certificate filled in by the funeral director, pag Hypothyroidism 1 ☐ Yes 2 🔀 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner' Hospital: 1 Yes 2 No Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ♣ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur ind title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D56950 November 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Nhaemeka Agajelu,

31. Date filed (Month

MD

1411 Madison Park Drive Suite 16

Glen Burnie, MD 21061

Birthplace (State or Foreign Country)

Black

10d. Inside City Limits 1 Yes 2 No

Approximate Interval Between

Onset and Death

Day

2 🗌 No

29d. Date signed (Month, Day, Year)

Year

Box 68760 P.O. Records,

 Hospital or Attending Physician: The 124 hours after death.
 Funeral Director: After this certificate h Division of Vital completely filled in by To the within 2 To the

Medical

29a. Certifier

31. Date filed (Month

29b. Signature and title of certifier

lame and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCIS KHOO, M.D. 7601 OSLER DRIVE TOWSON, MD 21204

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D30263

2 Medical Examiner: On the basis of examination and/or investigation, in rry opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38445 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:20 A Physician/ MOVEMBERay28 MARTAN FRIES Medical 4a. Facility Name (if not institution, give street and number)
FREDERICK MEMORIAL HOSPITAL Examiner 4c. County of Death . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 屎 F 96 Months Days Hours Min July 26, Year 915 159-24-5155 Canada Director Usual Residence of Decedent 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director MD Frederick Braddock Heights 1X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6923 Maryland Avenue 21714 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🐼 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Tom Lewko Helen Woywitka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rolaine Johnson - Daughter 6923 Maryland Avenue Braddock Heights, MD 21714 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State → Burial 2 ☐ Cremation 3 ☐ Removal from State 12-5-11 Vestal Hills Mem Pk. Vestal, New York 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Barber Memorial Home 428 Main Street Johnson City, NY a 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death MYOCARDIAL Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it only, each of the inneclate cause. Enter Underlying Examine Due to for as a nonsectionne on death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): sician a burial-t resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 1 ☐ Yes 2 ☑ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural 5 Pending Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ueath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title DOO 61410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 TOLL HOUSE HY, FREDERICK, 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 7:45 AM Reet V. Fidler OVEMBOR Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UPPBIL COBSAPPALLS 1755P17AZ BEZ ATR. HARFORD Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 144-38-1746 1076/1941 Estonia **Director** 70 Usual Residence of Decedent 28a-f show 10b. County 10a. State permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Abingdon TOO OTHSAM 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3118 Holly Berry Court 21009 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education 5+ NOVEMBER 29,201 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eduard Voorand Tiuu Valbe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy Fidler / Husband 3118 Holly Berry Court Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. 12/1/2011 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) METAS TATIC OUALIAN CAN CZK Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any acting to introduce cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ohysician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 PInpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fu 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nume Practiciner 12 the Center of my knowledge death occurred at the time, date and place, and one to the cause(c) and manner acceptance. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) ATTON DING PHYSICIAN 000 62239 NOVEMBER. 29 2011 MAW HAING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UPPER CITESA PEAKE 1705P17M egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 29 2011 Year Arthur E. Gardner Jr. Nov. 16:35M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Baltimore 3506 Buckboard Lane Middle River Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ÅM 2 □ F Months Days Hours Min. July7, 1956 213-68-2304 55 Director Yrs Germany Usual Residence of Decedent 9 item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10h County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland by Funeral Director 10d. Inside City Limits Baltimore MD Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 3506 Buckboard Lane USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X/es 2 No Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HeavyEquipment Operator Benjer Company 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o Arthur E. Gardner Sr. Carolyn V. Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Rita Gardner /wife 3506 Buckboard Lane Balto. MD 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Holly Hill Cemetery 12/5/1 Baltimore MD 4 Dogation 5 Other (Specify) Sign Jury of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ a. I pue to (or as a consequence of): Medical Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immedicause. Enter Underlying attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Day 1 ☐ Yes 2 ☐ Unknown been signed by should be detac Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Ninknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? 1 Yes 2 No 1 🗆 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury $5 \square$ Pending М 1 Tes 2 No within 24 hours after death

To the Funeral Director: ,
completed filled in by the: Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23s) (Type, Print) CI, Ly there ! lle 31. Date filed (Month, Day, State Registrar

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2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #18 Per FH G922 12/21/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38448 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Dav Year Delphina Greenwood-Davies 11:15 AM 2011 /Medical Usv 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death SINAL HOSPITAL 01-BALTIMORE BALTIMORF 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2X F Months Days Hours Min 213-62-3949 80 Director 03 Jamaica Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Exeminishment by notified at MD NA Baltimore Director 1 XYes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5720 Highgate Drive 21215 U.S.A. "natural", or items 23a Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 Specify: Black 1 ☐Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Long Green Nursing permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) 3yrs Home Certified Nursing Asst. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maider Surname) Be George Greenwood Adella Lactibeaucaire ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawnette Sodipo-Daughter 2403 Nora Ct., Forest Hill, Md 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State PATIENT Druid Ridge 12/3/2011 Pikesville, Md 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M22 Name and Advises of acity Þ 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL FNFARC TON ACUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a gunsaquinda of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burist-transt Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 RHEYMATOID ARTHRITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 ☑ No 2 **N**o 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၀ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 013377 19,2011 1 MJ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELVEDERE AVE, BALTIMORE West , MD 31. Date filed (Month, Day, Yea DEC 0 2 2011 32. Registrar's Sign State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38449 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 30, 2011 Physician/ Raffaele Golino Fabrizio 7:34 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13521 Esworthy Rd. Montgomery Darnestown 9. Birthplace (State or Foreign Country) Italy If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth Social Security Number Age (In yrs. last birthday, **Funeral** May 14, 1959 1**XX**M 2 □ F 52 579-62-9615 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location must be notified at Director MD Darnestown 1 Yes 2 X No Montgomery 10f Zip Code 9 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 20874 United States 13521 Esworthy Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, should be ince and Mental Hygiene is marked other than "natural", or item he Medical Examiner Black, White, etc. 1 Never Married 2 X Married Completed by within 72 hours after 1 Yes 2X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Consulting Computer Programer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last 2 R. Golino Lois Tavani Frank permit. Page 1 and 2 should be Department of Health and Men Important. If item 27 is marke any injury or other traumatic other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13521 Esworthy Rd, Darnestown, MD Lori M. Golino / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Bunal 2 XCremation 3 Removal from State Beltsville, MD Chesapeake Crematory 11/02/2011 4 Donation 5 Other (Specify) ature of Funeral Service Licensee Rappe To MeralFacind Cremation Services 20910 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final METASTATIC BRONCHOGENIC CARCINOMA Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown ed by the a g Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificate has been signed ral director, page 2 should be def Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 2 🗆 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital Other: 1 Tes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 📈 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State, Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title 11/30/11 026571 pleted cause of death (Item 23a) (Type, Print) 0605 CONCORD ST KENSINGTON, MD Z0895

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 28, 2011 3:30 p M Alan Francis Geyer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda 5014 Smallwood Drive 7. Age (In yrs. last birthday) Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 X M 2 🗆 F Months Days Hours New Jersey 80 **Director** 011-28-6936 Aug. Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director MD Montgomery Bethesda 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 20816 United States 5014 Smallwood Dr. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", White 3 🗌 Widowed 4 🗌 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Education Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Bailey Geyer Wehrly Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20816 5014 Smallwood Dr., Bethesda, MD Barbara G. Green / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory | 12/02/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral and Cremation Services 21. Signature of Funeral Service Licens MB 1539 Gist Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAYS Immediate Cause (Final Physician/ PNUEMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** YEARS ALZHEIMER'S DISEASE Sequentially list conditions cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed -tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an page 2 s has performed? this certificate Yes 2 👿 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\bar{X} \) Residence 6 \(\text{Other} \) Other (Specify, 1 🗆 Yes 2 KNo ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 \square Pending work'? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Division of Vital Records, hin 24 hours after death.

the Funeral Director: After impleted filled in by the funeral within To the

JV

State

Medical

29a. Certifier

only one)

29b. Signature and titl

30. Name and address of person who completed cau-DANIEL V. YOUNG M.D

certifier

of death (Item 23a) (Type, Print)

29c. License numbe D40219

1 & e fying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 — cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 — cylifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 2011

NOVEMBER 30.

4530 CONNECTICUT AVE. NW, #104, WASHINGTON D.C.

20016

31. Date filed (Month, Day, Year) Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		-	For State Registrar		State of Mis	ar yrai iu		tificate			al ICI IV	icinai i iy	Reg. N	26		38451	
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	Examin	er	Kline Hospice					Mt. Airy						4c. County of Death Frederick			
	Funeral	Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd					t birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)		9. Birthp Count	lace (State or Foreign lry)	
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Maryland	permit. Page 1 and 2 should be files Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic even once.	- 2	19a. Informant's Name/F Rolinda D V			er)						Freder:				Code)	
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ono	r Attending Phy ter death. rector: After this by the funeral o	ficat	2 Accident	Pending Investigation	(Month, Day	, Year)	injury	М	work?	? Yes 2□	No						
Division of Vital	I or Atte after de Directo	Certificate	3 Suicide 6 Could not be					ne, farm, street, factory, office 28				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Ω	the Hospital or Attending Physiciam: Thin 24 hours after death the Funeral Director, After this certific mpletely filled in by the funeral director,	edical		Certifying Physic	cian: To the best of	my knowled	dge, death o	occurred at	the time	, date and	place, a	nd due to the d	cause(s)	and man	ner as stat	ed.	
	To the He within 24 To the Fu	Med	(Check 2 1 only one) 3 0	Certifying Nurse	Practitioner: To the	e best of my	knowledge,	death occi	urred at th	ne time, da	occurred at the time, date and place, and due to the cause(s) and manner stated. ate and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)						
	6 ₩ 6 ©		Signature and title (S. Cortina				290	2001150)//1/	FI		29U. L	2/1	- II	-uj, 10w)	
			30. Name and address of	of person who co	mpleted cause of d	eath (Item 2	23a) (Type, P	rint)	<i>y</i> <u>U</u> <u>U</u>	_	11		١.	5 ())			
			3430 31. Date filed (Month, Da	War	NIK DY		NVI)) Si	171	<u> </u>	105) /Y(al	ICI	(ur) 21 10th	
	Sta Registra			0 2 201		ir's Signatu	ba	Kel									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38452 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Deemher Day Physician/ 420 A M ('ece 110 Thelma Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** erroll Mospital estminites erroll If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Days Mary land Months Hours Min. 218 07 6520 93 02/07/1918 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f sho 1 Yes 2 No Westminster Maryland Carroll Ö 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 307 Greengate Court Funeral 21158 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: white Completed 3 XWidowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Sales Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 James Bell Evan Gertrude Luers other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health as Important: If item 27 is any injury or other transponds Linda J. Hakes (daughter) 307 Greengate Court Westminster, Maryland 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Lakeview Mem. Gardens 12/5/2011 Donation 5 Other (Specify) Sykesville, Maryland Bruzdzinski Funeral Home PA 22. Name and Address of Facility ire of Funeral Service Licensee 1407 Old Eastern Avenue Essex Maryland 21221 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Enter the disease, or complications that caused to be heart failure. List only one cause on each line. shock. Immediate Cause (Final disease or condition resulting in death) Physician/ Abdominal tout Medical Due to (or as a consequence of) Examiner Hypo voleiniz Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Arute To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 38 attending | IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Thypertenlia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 26. Place of Death (Check only one 25. Was case referred to medical Be examiner? Other: 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ٩ Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: ocmpleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certiffe D 69036 01 MU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHINTY SHARMA MA Carroll Hospital Center. Registrar's ignatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** , Chai mbe 201 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 JM 2 🗆 F Months Days 69 **Director** June 15,1942 138-34-6359 Usual Residence of Deceder New Jersey Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 XYes 2 ☐ No ortant: If item 27 is marked other than "natural", or items 23a or 28a-f s injury or other traumatic event, the Medical Examiner must be notified Md. Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21224 USA 7526 Lange Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐XNo Specify à Specify: 3 Widowed 4 XDivorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food 12 6 Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental H Mary Maran Edmund C. Gage ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Springhill, Tennessee 37174 DTR. 2653 Danbury Circle Gwen Montgomery 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parkville, Md. Parkwood Cemetery 12-2-2011 4 Donation 5 Other (Specify) 21. Signature of Funcial Service Licensee 22. Name and Address of Facility Miller-Dipple Funeral Home, Inc. Balto.Md. 21206 6415 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Probable **Physician** Cardial Infacction disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed pue resulting in death) Last Due to (or as a consequence of) physician is the buria Box 68760 Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 2 □ No 5 Other (specify) Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 Yes 2 No 2 10 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 1 Yes 2 1/No 2 R/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) this eral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 Yes 2 No 2 Accident Director: A 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 4 - Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00068258 November 24,2011

State
Registrar

11595

4940 Eastern Avenue, Baltimore, MD, 21224

seine ge

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Shirley Teresa Gaa Nov. 2011 1:45 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7411 School Lane Dunda1k Baltimore Co. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 19, 1959 **Funeral** 9. Birthplace (State or Foreign Months Min. Director Maryland 219-76-9059 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Baltimore Dunda1k 1 Yes 2 No 10e, Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 7411 School Lane 21222 United States items ? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. ō 1X Never Married 2 ☐ Married þ hours after Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify "natural", 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years 4 Years Research Lab Technician University of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ George Arthur Gaa, Sr. Lillian Gertrude Houston traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lucille Wilkinson(Partner) 7411 School Lane Dundalk, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 11/30/2011 Towson, Maryland 21. Signature of Funeral S Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition au Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that initiated events sician and burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 phy: attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Pregnant at time of death Day Year ed by the detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown been signated by the second of Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performe certificate 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title

State Registrar 31. Date filed (

Month. Dav, Year,

Name and address of person who completed cause of death (Item 23a) (Type, Print WW & Shalley (670) N. Charles

D007128

29d. Date signed (Month. Day. Year.

Ste. 4105, Baltimore, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ Year PGARE 0900AM Medical DOCOMBER 4b. City, Town, or Location of Death **Examiner** 4c. County of Death KERSGIL BAUTIMORE owsen 5. Social Security Number 8. Date of Birth (Month, Day, Apr 15, 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖵 F West Virginia 1911 Director 233-28-5135 100 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 X No MD Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 615 Chestnut Avenue 21204 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fred Wilfong Daisy Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Gaziano friend 3391 Reedy Drive; Annandale, VA 22003 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🏝 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 1 Other (Specify) Hilltop Service Corp. 12/6/2011 Towson, MD 21. Signature of Fund 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complicati that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one of on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician **ESOPHAGEAL** Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying by Physician/Medical Examiner Due to for as a consequence of Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OSTEU POROSIS Completed 2 No 3 Probably 4 Unknown After this certificate has been sirenneral director, page 2 should it 24b. Were autopsy findings available 24a. Was an ANDMIA prior to completion of cause of ONGESTIVE HEADT PAILUPE 1 Yes 2 No the funeral director. 25. Was case referred to medica Be 26. Place of Deat (Check only one) examiner? 2 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No after death. Accident Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name 10

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Vovember 12:59 AM John Hendrickson Medical 4c. County of Death

Baltimore Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ph Medical 70W50N Center 05e g. Birthplace (State or Foreign Year If Under 24 Hrs. 8. Date of Birth If Under **Funeral** Days Hours (Month, Day, Year) Country 216-32-8960 1 X M 2 □ F Director Maryland June 26, 1935 76 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b County 10c. City, Town or Location with the Maryland must be notified at Director 1 Yes 2 No Towson Raltimore 10g. Citizen of What Country? 10f. Zip Code ò Funeral 21204 23a 11 West Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married or 2 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after black 1 ☐ Yes 2 💢 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) transportation truck driver of Health and Mental Hygie If item 27 is marked other r other traumatic event, the Be unk Page 1 and 2 should be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna Dixon ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau 1348 Pentridge Road Baltimore, MD Karen Glasgow/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🖁 Other (Specify) /oin state State and Affattomy Board 655 W. Baltimore Street v e of Eur Rona Sign Director 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ⊦h, i ian/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury Exam and as the burial-trai that initiated events Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months? Day Month 2 No detached g Unknown g Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? has performed? Yes 2 N 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗙 No ည 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, . Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: Year injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: 7) the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Ceptifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2gb. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person

1ant

Drive Towson, MD 21204

who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month V. Physician/ Kobert Medical 4b. City, Town, or Location of Death County of Death **Examiner** Gilchrist Baltimore FOWSON enter Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months 1 **№** M 2 🗆 F Director 83 Yrs BALTIMORE ML 28a-f show 10a. State 10c. City, Town or Location Funeral Director ms 23a or 28a-f s must be notified 1 Yes 2 No AM BALTIMORE rktor 10g. Citizen of What Country? 21120 1)54 Molesworth 205 items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or itel dical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify If Yes, Give Year or Dates White 3 XWidowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Manging on other traumatic event, the Mones. Government CCOUNT ANT Be 18. Mother's Name (First, Middle, Maide 17. Father's Name (First, Middle, Last) ဂ္ 19a. Informant's Name/Relationship (Type, Print 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 29/11 Forest HILL, YORK RDS MONKTON, MD ZIIII FUNERAL CHAROL+ CREMATION SERVICES MONETON eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between 23a. Part 1. Enter the disease, shock, or heart failure. Lis set and Death Immediate Cause (Final COREBROVASCULAR ACCIDENT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pt d for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregpant 3 Ectopic pregnancy in the past 12 mo Month Day Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached i 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 2 No 3 Probably 4 Unknown Division of Vital Records, Completed CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? autopsy ATRIAL FIBRILLATION perform 1 🗌 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d, Describe how injury occurred 27. Manner of Death Certificate: 1 Avatural within 24 hours alter ניסיי.

To the Funeral Director: Afte 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 06-2011

State

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38458 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Husain 2011 2057 Uzra November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) lov 9, 1930 1 □ M 2 🖵 F 020-63-0398 81 **Director** India Nov Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 ☐ No MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 20817 7501 Democracy Blvd. #431 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: Asian Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha permit, Page 1 and Department of Health and Mentan 1135 Important: If item 27 is marked other the 1131 in intro or other traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Amin Ahmed Begum Ahmed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Taher Husain - Son 218 Watkins Pond Blvd. Rockville, MD 20850 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Parklawn Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 11-27-11 Rockville, MD 22. Name and Address of Facility Serenity Funeral Service 14640 Flint Lee Rd Chantilly. A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between mmediate Cause (Final Onset and Death Physician/ disease or condition Respiratory Arrest Medical resulting in death) Due to (or as a consequence of) **Examiner** Нурохіа Sequentially list conditions, Examine Due to (or as a consequence of, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi Cardiac Arrest and Due to (or as a consequence of) Physician/Medical be detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 \square Yes 2 $\frac{1}{X}$ No 3 \square Probably 4 \square Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2X No 1 Yes 2 No 25. Was case referred to medical Vital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Mnpatient 2 ER/Outpatient 3 DOA funeral ₹ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No ☐ Accident Investigation within 24 hours after deat To the Funeral Director: 3
Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) November 25, 2011 005126 MO

State Registrar

DHMH 17 Rev 7/2009

8600 Old Georgetown Rd. Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nancy Lawless, MD

DEC 0 2 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38459 Reg. No. 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month -2011 1530 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Dec 30, ^{Ye}1936 New York **Director** 077-34-9724 1 🗆 M 2 🛛 F 74 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2X No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 5333 High Tor Hill 21045 USA items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 0 Black, White, etc. þ 1 Never Married 2 Married ld be filed within 72 hours after Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 Widowed 4X Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Art Therapist 5+Social Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ Robert Victor Cox Marjorie Donnan and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Wade Powell Hampton/son P.O. Box 165 Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 11/26/11 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Se Cing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the prease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Septic disease or condition Medical resulting in death) Due to (or s a consequence of) Examiner Coliti Sequentially list conditions, cause. Enter Underlying Exam Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buris Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year Pregnant at time of death the 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown P.O. signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page perform death? 2 No 2 X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Yes within 24 hours after deam.

To the Funeral Director: After this of normaletely filled in by the funeral di 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of ath Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred atural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Usertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3[Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titl ertifie 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 75,5 cedar La colunbia MO Mb 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 1001 29 2011 ll Mary Louise Hart /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedal If Under 1 Year | If Under 24 Hrs. Baltimore Square Hospital FRANKLIN 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Days Min. 1 □ M 2 XF Months Hours 12-25-1921 Maryland 89 Director 212-20-5525 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Exeminer must be nutified at 1 ☐ Yes 2 X No Balto. Nottingham Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 4101 Walter Avenue Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1
Yes 2
No 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White "natural", or 1 ☐ Yes 2 X No Yes Give Specify: Specify: þ iit. Pages 1 and 2 should be filed within 72 moundarment of Health and Mental Hygiene. 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Operator 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary E. Francis Elmer Hart ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: if item 27 is any injury or other trau once. Perry Hall, Md. 21128 9133 Cowenton Avenue Nephew Michael Hart 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park 12-1-2011 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) Schimunek Funeral Home, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service 1 Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician accident 7 days disease or condition resulting in death) Cerebrovascular /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ 10 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has be irector, page 2 sl autopsy performed' 1 ∐Yes 2 ☑No 2 ANO 1 ☐ Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation fter dea h. 2 Accident Director d in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours

To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 11-29-2011 06952

Registrar

DHMH 17 Rev 1/2001

State

4000 FRANKLIN SQUESE DR Balto md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37. Registrar's Signature

Warren Ho, MD

31. Date filed (Month, Day, Year) DEC 0 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38461 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy L. Harris November 30, 2011 4:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rock Spring Village Forest Hill Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2XX 91 Months Days Hours Min (Month, Day Yea) Director 220-09-5698 Maryland Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2XXNo Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2637 Smallwood Drive 21009 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XXo Specify: White If Yes Give 3 Widowed 4 ☐ Divorced Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Glen L. Martin Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Robert B. Milwee Lillian Lay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Harris (son) 2637 Smallwood Drive, Abingdon, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1

Byfial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) nation 5 Other (Specify) 12/3/2011 Bel Air Mem. Gardens Bel Air, Maryland 21. Sign tyre of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Bel Ait 610 W. MacPhail Road, Bel Air, MD Next 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ stage dermente Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or finjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) / the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 2 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ည 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work?
1 Yes 2 No 1 Natural Accident Investigation within 24 hours after death

To the Funeral Director; /
completed filled in by the f Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3225 December 1 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAZ.D 6. Tw. Ma. 5 33.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0745 M 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner 4b. Citv. r Location of Death 51 Coreene reet ASADENA If Under Security Number Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 D F Months Days Hours 216-05-9374 94 Maryland Director 1917 Apr. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 21122 United States 303 Green Drive items ? death 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ed Forces? Yes 2 \sum No Black, White, etc. ö by 1 Never Married 2 Married X Yes within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates. WW 2 1 ☐ Yes 2 X No Specify: Specify. "natural" White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Electician Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked of r other traumatic ever 2 Edna Ford pe. Frederick Hemstetter Page 1 and 2 should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 319 Najoles Rd., Millersville, Maryland 21108 Thomas D. Hemstetter, Jr./Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other plant of Crematory, December 1 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State Înc. 2011 Catonsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fune al Servi kley-Ruddick Funeral Home, P.A. Crain Hwy., S.E., Glen Burnie, Licens MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus, on each line. Onset and Death Immediate Cause (Final Physician) teriosel disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of law requires that the death certificate be executed -tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 🗌 No the g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, pane 2 o autopsy 2 🗌 No Yes 1 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 2 Accident Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending work?
1 \(\sum \) Yes 2 \(\sum \) No iniury 5 Pending death. Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined after Hospital hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 24 (Check within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier puty 29c. License number 29d. Date sigged (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

America

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11^{Month} 29^{Day} 20°11 7:42 Α Alvin Howard Holter Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Worcester Berlin 79 Club House Dr. If Under 1 Year If Under 24 Hrs Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☒ M 2 ☐ F Months Days Hours 3 /17 94 926 85 MD Director 216-20-1528 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City. Town or Location Director Berlin 1 Yes 2X No MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be n Funeral USA 21811 79 Club House Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status er than "natural", or ite the Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. n 27 is marked other than " er traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Plastic Agent Purchasing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Heath and Mental Important: If item 27 is marked cary injuy or other traumatic evenore. ပ Mary Rosenberger Howard J. Holter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Holter - Wife 79 Club House Drive Berlin, Maryland 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Sacred Heart of Jesus 12/03/2011 Baltimore, Maryland Donation 5 Other (Specify) Cemetery

22. Name and Address of Facility
David J. Weber Funeral Homes P.A.

5311 Edmondson Avenue Baltimore, f Funeral Se Signature Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 11/10 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner (r as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): physician Physician/Medical or Attending Physician; The law requires that the death certificate be P.O. Box 68760 ding IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) been signed by the atte should be detached for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 ☐ Yes 2 ☐ No 210 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registr<u>ar</u> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

31. Date filed (Month, Day, Year)
DEC 0 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38464 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month OLM ES 12.15A FODAR Medical 13 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY BURTONSVILLE SANCTUARY AT HOLY CROSS Social Security Number If Under 1 Year If Under 24 Hrs. Sex 1 X M 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign Country) PENNA • Age (In vrs. last birthday) **Funeral** Months Hours MOTH PE-1939 72 **Director** 192-32-2923 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No HOWARD COLUMBIA MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21044 USA 4935 COLUMBIA RD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Evel Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ь by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural", Specify: BLACK Completed 3 ☐ Widowed 4 🎇 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) -12-BUSINESS OWNER FOOD Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any jury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည SARAH WILSON CLEO G. HOLMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERN WINFIELD (DAUGHTER) 7385 SWANN POINT WAY COLUMBIA, MARYLAND 21045 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 12-1-2011 BALTIMORE, MARYLAND METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sa D. HIBNER^{2. Name and Address of Facility}PHILLIPS FUNERAL HOME, P.A. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1 Enter the disease, or complications that caused shock or heart failure. List only one cause on each line. Immediate Cause (Final Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death MYOPATHY Physician/ DIO disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death 2 No s been signed by the s should be detached g 🗌 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by MELLIFUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has autopsy performed 1 🗌 Yes 29 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manper of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural injury To the nosperation within 24 hours after death.

To the Funeral Director: Aft 5 Pending work Accident 1 Tes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Morpth, Day, Year) my serreen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITH

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. For State Registrar 38465 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Albertha Hoyer 03:46 PM Medical Facility Name (if not institution, give stree 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Warsland Med Ballimore If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. 12/23/1938 72 Virgin Islands Director 1 M 2XXF Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director White Plains NY Westchester 1 🗌 Yes 2 💢 No 10f. Zip Code 10603 10e. Street and Number
213 Church Street 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 X No Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunication Communication Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Althea Harris ဂ Amatus Hoyer 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is m any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Toyo, State, Zio Code) 4005 McDowell Lane, Halethorpe, MD 21227 Alexis M. Rising / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/30/2011 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall ryland Cremation Services Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ al nous disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or injury that initiated events and resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Live Fees Pregnant at time of death in the past 12 months? Month Day Year signed by the all d be detached for 2 No Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Hospital 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. neral Director: After this in y filled in by the funeral di this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 24 hours Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner 1. the best of my knowledge death occurred at the time, date and place and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of

Registrar
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Medina

31. Date filed (Month,

			State 1 - State Amend Items 23aPt	e of Maryland / De 1,11,27 per d				9	38466	
					ertificate of				00100	
	Physicia /Medic		Decedent's Name (First, Middle, Last) Annie Johnson	2. Date Monti Nove	n Day	y Year 0, 2011	3. Time of Death 12:00 P ^M			
· N	Examin	er	4a. Facility Name (If not institution, give street and	d number)	4b. City, Town, o	r Location of Death	4c.	County of Death		
			Future Care - Coldsp		Baltin					
	Funeral		5. Social Security Number 6. Sex 1 □ M 2 🗓	7. Age (In yrs. last birthd	Months Days		of Birth h, Day, Year)	9. Birth	place (State or Foreign intry)	
IJ.	Director		228-50-3373	75 Yrs		\$ept	29, 19	36 Vir	ginia	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits	
	e Maryla a-f sho tiffed at	ctor	VA Warshaw						1 ☐ Yes 2 No	
:	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	al Director	10e. Street and Number 13205 History Land H	wy	10f. Zip Code 22572	2		izen of What Cou SA	intry?	
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9500-c1	in 72 h	Completed	15. Decedent's Education (Specify only highest grade comple	ted) (G	ecedent's Usual Occup live kind of work done le. DO NOT use retire	oation during most of working d)	16b. Ki	ind of Business/l	ndustry	
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and	d be ental ked c	To Be	Ellis Arthur Johnson	L		Bertha Ire	ne Scot	t Johns	ınson	
<u></u>	Shoul nd Mi	F	19a. Informant's Name/Relationship (Type. Print)	19h M	ailing Address (Street	and Number or Rural Route N				
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a)	Hea Hea		20a. Method of Disposition	20b. Place of Dis	sposition (Name of	Date		ocation - City or 1	own State	
Daillinor	Pages ment of ant: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal f 4 ☐ Donation 5 🕅 Other (Specify) in	rom State cemetery, o	crematory or other plac	ce) ¦			om, oato	
0a 0	permit. Depart Import any Inj once.		21. Signature of Funeral Service Licensee Ronald S. Waye	Director		ss of Facility State Ar altimore St; H	-		21201	
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	otta		23a. Part Enter the discase, or complications the shock, heart failure. List only one cause	nat caused the death. Do not on each line.	enter the mode of dyir	ng, such as cardiac or respirat	ory arrest,		Approximate Interval Between	
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	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
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	he de	sic		regnant at time of death nknown	5 Other (specify)			Worth Day		
	hat the d by letac	P	Part II. Other significant conditions contributing	to dooth but not regulting in the		an in Deat I	Did tabasa.		the cause of death?	
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	the pag	် ဂ				1□,	performed? es 2 No	death?	2 □ No	
3 .	ding Physician: The lav n. After this certificate has funeral director, page 2 ²	Be	25. Was case referred to medical examiner?			26. Place of Death (Check	only one)			
	hysi his o	၉	O 1 Yes 2 No Hospital: 1 Inpatient 2 TER/Outpatient 3 T DOA Other: 4 Nursing Home 5 T Registered 6 Tother (Co.							
=	ng P	ä	27. Manner of Death 28a. □ 1 XNatural 5 □ Pending	ribe how injur	jury occurred					
2 .	tendi eath. or: A	ä	2 ☐ Accident investigation		28c. Injury at Work? M 1 Yes 2 No					
	ai or Ati s after de il Direct d in by i	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Euneral after death. To the Euneral after death. Completely filled in by the funeral director, page 2 should be detached for use as the I	Medical	Z Medica: Examiner: On t	o the best of my knowledge, de ne basis of examination and/or manner stated.	eath occurred at the til r investigation, in my c	me, date and place, and due to opinion, death occurred at the	the cause(s)) and manner as d place, and due	stated. to the cause(s)	
	Vithi Com		25d. Date signed (World),							
7			I know and	- Wo	Doc	169314	11	10/11		
•			30. Name and address of person who completed	cause of death (Item 23a) (Typ	pe, Print)	Ra Perrent/t	e m	212	<u>د</u>	
	Stat			2. Registrar's Signature		,			`	

State Registrar

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Bener B. parks

11-08946 John King

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Madical Examiner 0827 hrs John H. King November 28, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 209 Mace Avenue **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Funeral 212-88-7935 Months Director March31,1965 Country)MD 46 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Essex 1 Yes 2 No mit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygone. protant: If item 27 is marked other than "natural", or items 23a or 28a-f sho protant: If item 27 is marked other than "natural", or items 23a or 28a-f sho protant: Two other trannatic event, the Modical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 MAce Avenue 21221 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married White, etc. 1 Yes 3 Widowed 4 Divorced If Yes, Give Yeer Yes 2 No specify: White Specify: Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maintence Man St. Peter Church 10th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Dennis Sears King Ruth Ann Krach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Ann King /mother 209 Mace Avenue Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory of other place)
Holly Hill Cemetery 12/3/1 1 XBurial 2 Cremation 3 Removal from State Baltimore MD Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex Part I. Enter the disease, or complications th caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Mextinal Death Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ner Due to (or as a ronsequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical AMENDED 23a, pt. II, 27, per me, g922 12-16-11 sm X UNPENDED attending physician or use as the burial -To the Hospital or Attendiog Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 ě 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Yes 2 No 3 Probably 4 Unknown Cocaine Use Completed 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene After this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Liver within 24 hours after death.

To the Funeral Director: A 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E. November 29, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year) State Registrar

ORIĞINAL

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Funeral		Friends Nursing 5. Social Security Number		Sandy S Inder 1 Year	pring If Under 24 H	Irs. 8. Date of E		Montgo		ace (State or Fore	e <i>io</i> n			
Director		552-38-6447 Usual Residence of Decedent	82	Nonths Days Hours Min. Apr					29 1	New .				
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	MD Montgo	omery	10c. City, Town	Sprin	g	***		La	211		1 Yes 2		
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nd 2 shoul ealth and 1 m 27 is ma		19a. Informant's Name/Relationsh Dorothy W. Kolt	nip (Type, Pnint) Cnow/wife	19t	Mailing Ad	dress (Street a Leisu	and Number or re Worl	Rural Route Numi d Blvd.	#401	or Town Sta	te, Zip Co e r Sj	pring, M	D	
. Page 1 a Iment of H tant: If ite jury or oth		20a. Method of Disposition 1 ☐ Burial 2 🏹 Cremation 4 ☐ Donation 5 ☐ Other (S		20b. Place o cemete Final	ery, crematory	or other plac		Date 12/03/11		Location - C dbine		vn, State		
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al or Atter s after des al Director ed in by th	Medical Certificate:	3 Suicide 6 Could i 4 Homicide determ	not be	arm, street, fa	actory, office			(Street and Number or Rural Route Number, wn, State)						
To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s		29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											tated	
10 V V		- /1	Venu			29c. License D3579				ate signed (f ember				
141.9		30. Name and address of Gerson who completed cause of death (tem 23a) (Type, Print) Merlyn K. Vemury, M.D. 9801 Georgia Ave. #227 Silver Spring, MD 20902												
Stat Registra		31. Date filed (Month, Day, Year) —	2011	rar's Signature	face	N								

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 29. MAE KOWITT 2011 4:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AATHOME FAMILY PLACE COLUMBIA HOWARD Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/25/1916 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Hours 1 □ M 2 👿 F Min. Country) 263-18-2154 95 **Director** NY Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits HOWARD FULTON 1 🗌 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7677 PRESIDENT STREET 20759 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Ş Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed 3 - Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 BONDS CLERK BANKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. ABRAHAM MORRIS LINA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA STOREY / DAUGHTER 7677 PRESIDENT STREET FULTON, MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM 12/01/2011 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Li 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Alterosclerotic Cardovascalar Disease Onset and Death Priysician disease or condition resulting in death) - Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day 9 Unknown Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy certificate 1 Yes 2 No 1 Tyes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: မ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation within 24 hours after deal To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 1) 306 41 40 vember 30 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 n meh Sabanalhi 201-109 Back RIVU MCK 2/2 31. Date filed (Month, Day, Year State 02 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11, 2011 **Physician** 12:30 AM November Henry Loss /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Riverview Nursing & Rehab Essex 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 6, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1⊠ M 2□ F 86 Director 218-18-7451 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 28a-f show id other than "natural", or items 23a or 28a-f show event, it a Myslical Exstantion in the periodical Director 1 ☐ Yes 2 ☑ No Baltimore Middle River 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Items 23a 10044 Icabod Lane 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 □ No If Yes, Give Year or Dates: 1943 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify. white Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wn Department of Health and Mental Hygien Important: If item 27 is marked other that any injury or other traumatic entering once. merhcant marines 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Madeline Wisenboad Alferd Loss ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 723 Bedford Road Bel Air, MD 21014 Cheryl Stree/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Funeral 22.Name and Address of Facility Board 655 W. Baltimore Street w 21201 Baltimore, MD ort 1. Enter the disease, or complications that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) / /Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-trar Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 5 Other (specify) P.0. ed by the detached 9 Unknown 9 Unknown signed be Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed 2 No 1 ☐ Yes 1 □Yes 2 DNo Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural
2 Accident 5 Pending 24 hours after death.

e Funeral Director: Af elletely filled in by the fur 1 □Yes 2 □No investigation 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nonth 2352 M Catherine Medical McCov 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death George's Hospita Chever/ Year If Under 24 Hrs 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🏲 F **Director** 578-84-2766 Usual Residence of Decedent 48 6/6/1963 DC show 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges MD Landover Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6707 Munsey Street 20784 USA items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 HNo Specify: 3 Widowed 4 Divorced 'natural" Completed Specify: Black 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Site to NOT use retired Fficer
Home Care Nursing 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! Louie B. Covington Patricia Best 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Landover, MD 20784 Department of Health ar Important: If item 27 is any injury or other trauonce. Patricia Isaac /Mother 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ 6 ther (Specify) Heritage Memoria 12/1/11 Waldorf, MD 21. Signature of Fun Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. cc0278 3831 Georgia Ave. NW Washington,DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscherotic Cardiovascular Phy it it it disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: Exami Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death ed by the ar 1 Yes 2 Unknown 2 No Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examinera 1 Yes Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After if filled in by the funer work? 1 🗋 Yes 2 🗌 No 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C Medical Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar salvador

31. Date filed (Month, Day, Year,

7001

Hos

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38472 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ .Month Nicole Matthews 606 November Medical 4c. County of Death $\overset{\text{4c. County of Death}}{N}\overset{\text{A}}{A}$ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Agnes Hospital Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (*ln yrs*. **39** 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Country 220-84-8453 Months Days Hours Min. 6 (Manth, Pay Xear) Director Usual Residence of Decedent 10b. County N/A or 28a-f show notified at 10a. State 10c. City, Town or Location Baltimore death with the Maryland 10d. Inside City Limits Director 1 Yes 2 □ No 10f. Zip Code 21216 10e. Street and Number. 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important. If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be ronce. Funeral 3319 W. Forest Park Ave 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian African Specify: Amer. 1 Never Married 2 ☐ Married ģ 1 ☐ Yes 2 K No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hotel Elementary/Seconday (0-12) College (1-4 or 5+) House Keeping 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Edward E. Matthews SANDRA J. PAGE 19a. Informant's Name/Relationship (Type, Print)
Judy C. Bell/Aunt Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
W. Forest Park Dr., Balt., MD 21216 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Balt., MD 12/5/11 Zion Cem. 4 ☐ Donation ∫5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service License 23a, Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) LIVER FAILURE weeks Medical Due to (or as a consequence of): Examiner Hepatitis B Sequentially list conditions, if any, leading to immediate cause. In the Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician the driving the burial Physician/Medical 48RO ESRD P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No Yes 2 No 1 Tyes Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 X.No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature P25907 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 9,00 S. CATON AVE BALTIMORE, MD JUFFREDA 3/ Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Mathews, N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Moore 4:00a 27 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kensington Montgomery Kensington Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** (Month, Day, Hours 79 Director 219-28-1514 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 1 🗌 Yes 2 🔀 No Kensington MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 20895 3000 McComas Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12th grade College (1-4 or 5+) Federal Government Admin. Asst. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ardelia Dixon Phillip Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6317 Park Heights Ave Unit 620, Caleb Craig-Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Maryland National 12/1/2011 Laurel, 4 Donation 5 Other (Specify) March Fr West 4360 Wabash Ave, Baltimore, Md 21215 anature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Onset and Death immediate Cause (Final disease or condition resulting in death) FAILURE Physician CONGESTIVE HEART Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi and The law requires that the death certificate be exec Due to (or as a consequence of) ng physician as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE ttendin or use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12,months? 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ₩No 3 □ Probably 4 □ Unknown 1 Tyes Completed page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death?

1 Yes 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 W Nursing Home 5 Residence 6 Other (Specify) 2 🎔 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Tes 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ひつつご suo, mo 11130111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	4	For State		State o	f Marylan	-				and M	iental Hy	/gien	e 20		381	
		Registrar 1. Decedent's Name (First, Middle, La	ast)		Cer	tificate	of L	eath		2. Date of D	Reg. N	No. 2 (1 1	1	
Physician Medica	Mildred Martin										Novem1		23, 2	51°1	3. Time of Dea 6:45	th M
Examine	r 4	a. Facility Name (if no Suburban			ber)		4b. City, To Beth			of Death	4c. County of Deat Montgome				v	
Funeral	5	. Social Security Nun	-		7. Age (In yrs. la	ast birthday)	If Under 1	Year	If Under		8. Date of Bi	irth	T		lace (State or Fo	reign
Director		479-18-746		1 □ м 🕱🖾 г	89	Yrs.	Months	Days	Hours	Min.	(Month, D 9/29/1)	Count		
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within 72 hours after giener than "natural", o ; the Medical Exam	Ω Β	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give Year or Date)	Yes 2	K No	Specify:				Specify:	te			
21215-003 rithin 72 hours at lene. r than "natural" the Medical Exa		15. Decedent's Education (Specify only highest grade complet			16a. Decede					of workin	na	16b.	Kind of Busi	ness/Ind	ustry	_
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d 2 led will Hygie other ent, th		7. Father's Name (Fir	st. Middle, Last)	5+		Teach	er	Т	19 Motho	r'a Nama	(First, Middle			1		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	٦ I	Frederick									Griewe	, iviaidei	n Surname)			
and Nand Is made is made and i	F	19a. Informant's Nam	e/Relationship (Type, Print)		19b. Mailing	g Address (S	Street ar	nd Number	r or Rural	Route Numb	er, City o	or Town, Sta	te, Zip Cı	ode)	
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ge 1 a st of H ite	2	0a. Method of Dispos	Cremation 3	Removal from S	CE CE	lace of Dispos emetery, crem	atory or oth	er place	,		ate	1	Location - C	•		
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Depert any i		1. Signatur in iner	21)				Name and			10100-016					11/11 01.00	
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O. Box 68 tt the death certifit by the attending etached for use a	2	3b. Was decedent pro	nths?	23c. If yes, outcome 1 Live B	irth 2 🗌 Fetal	death 3						1	23d. Date		-	
BOX ne death c the atten ched for u		1 Yes 2 1	No	4 ☐ Pregna 9 ☐ Unkno	ant at time of de own	eath 5∐	Other (spec	cify)			-		Month	ı L	Day Year	
s that the gned by the be detach	٦ ا	art II. Other significa					derlying ca	use give	n in Part I.		23e. Di d t	obacco	use contribu	ute to the	e cause of death?	,
dS, tuires an sign	metatatic renal pelvis carcinoma								Yes 2	2 No 3 □ Probably 4 □ Unkno						
aw rec	1										24a. Was auto		24b. We	re autops	sy findings availa	ble
DIVISION OF VITAI HECONDS, tall or Attending Physician: The law requires is after clearth. In Director: After this certificate has been signed in by the funeral director, page 2 should be Certificate: To Be Completed.											perfo	ormed?	dea	ath?	_	Oi
ician: Sertific rector,	2	5. Was case referred examiner?		Hospital:		_		LO4L	e of Death	n (Check d	only one)					
Physical directions		1 ☐ Yes 2 1 1 7. Manner of Death	No	1 V Ir	npatient 2 🗆 E	R/Outpatient 28b. Time of		Other:	4 ∟ Nur		ne 5 🗆 Resi			Specify)		_
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IVISION OI or Attending F after death. Director: After t I in by the funer.			Could not be determined	28e. Place o	of Injury - At hon	ne, farm, stree	et, factory, c	office		2				or Rural F	Route Number,	
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he Hospita in 24 hours he Funera pletely fille	2	(Check 2 L.	Medical Exam	sician: To the besiner: On the basis	of examination	and/or investig	ation, in my	opinion.	death occ	curred at the	he time date a	and plac	e and due to	the caus	ee/s) and manner of	tate
o the o the comple		only one) 3 🗆	of certifier	se Practitioner:	To the best of m	y knowledge, c	death occurr	ed at the icense r	time, date	and place	e, and due to	the caus	e(s) and man ate signed (A	ner as sta	ated.	
F > F 0) () () -	Ht.	W. 4	-		_	700	[7			11		ionin, De	iy, rear)	
. 1	30). Name and address	of person who	completed cause	of death (Item :	23a) (Type, Pri	int)		W (2001=		0 1 1 9	on_		
10 1	21	Cynthia C		- A La				ethe	esda,	MD	20817					
State Registrar	٥		FC 0 2 2	011	war's Signatu	1. 30	west									
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Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38475 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:55 Patricia Russell Morgan p_M Medical 2011 November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2XX Days Hours Min. June 23, 1938 United Kingdom **Director** 219-34-9772 Usual Residence of Decede items 23a or 28a-f shov ner must be notified at 10b. County 10a. State death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Bethesda Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 20817 10g. Citizen of What Country? Funeral 6729 Newbold Drive USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 0 þ 1 Never Married 2 Married 1 Yes 2XXNo Baltimore, Maryland 21215-0036 filed within 72 hours after White 1 Yes 2 No Specify: "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 5+ Development Director Education other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve once. and Mental ည Minna Gardner Edward Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $9202 \ \ Shelton \ \ St. \ \ Bethesda, \ \ MD \ \ \ 20817$ Heather K. Morgan, daughter 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Chesapeake Crematory 11/30/2011 Beltsville, MD 4 Donation 5 Other (Specify) Rapp Funeral & Cremation Svcs. 21. Signat ... et Funeral sevice Licens 22. Name and Address of Facility KHZ. Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Chronic Kidney Disease Physician/ disease or condition resulting in death) vear Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day 1 Yes 2 = 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? congestive heart failure, chronic obstructive Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown pulmonary disease Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 autopsy this certificate har performed? Yes 2 No death?
1 Yes 2 No Hospital or Attending Physician; The Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔼 No Hospital မ Other: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred XX Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral C completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) D37891 11/27/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 √ Rajvanshi, MD 121 Congressional Ln # 409 Rockville, MD 20842 31. Date filed (Month, Day, State

Registrar

DEC 0 2 2011

PATRICIA

NAN

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38476 201 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth Ann McCarthy November 28, 2011 7:40 A M Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Stella Maris Nursing Home Timonium 5. Social Security Number **Funeral** Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F May 8, 1924 216-16-1706 Hours 87 Director Baltimore, MD Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Middle River MD 1 ☐ Yes 2 🛣 No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 6 Tearose Drive 21220 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 2 1 \square Never Married 2 \square Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕍No Specify. White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Banking Teller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Joshua Levering Merritt Sarah Ethel Sparks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Denby Circle Clayton, NC 27527 Barbara Wolford-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 1 \square Burial 2 X Cremation 3 \square Removal from State Evans Funeral 4 Donation 5 Other (Specify) 30, 2011 Forest Hill, MD Chapel - Bel Air 21. Sig F tyre of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

Control Immediate Cause (Final HEART FAILURE CONGESTIVE Physician/ ase or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): NOVEMBER Physician/Medical Box 68760 attending phy 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached in 9 Unknown ELIZABETH McCARTHY Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown renol Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 은 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier valle R 043580 11-28-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

2300 DULANEY VALLEY ROAD

CRNP

JUSTINE PREIS,

DEC 0 2 2011

31. Date filed (Month, Day, Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 24, 20°I1 5:20 P M MARY YOLANDA MACHESNEY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BEL AIR UPPER CHESAPEAKE MEDICAL CENTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Months Days Hours (Month, Day, Year) 54 568-35-9776 Director 3/24/1957 TLLINOIS Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits at with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 Yes X No HARFORD **EDGEWOOD** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 416 TRIMBLE FIELDS DR 21040 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. WHITE 1 Never Married 2 K Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) STATE OF MARYLAND SURGICAL DENTAL ASSISTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EDWARD BOLICH YOLANDA SUBIA 19a. Informant's Name/Relationship (Type, Print)
THOMAS MACHESNEY-HUSBAND 19b, Mailing Address (Street and Number of Fural Route Number City or Town, State Zie Code) 416 TRIMBLE FIELDS DR EDGEWOOD, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/27/11 GLEN BURNIE, MD TLANTIC CREMATORY 22. Name and Address of FacilitySCHIMUNEK FUNERAL HOME OF BELAIR Signature of Funeral Service Licenses 2011 MD 21014 BEL AIR, 610 W. MACPHAIL RD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24, Immediate Cause (Final Physician/ Multiorgan disease or condition resulting in death) Medical November **Examiner** Ischemi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examine physician and s the burial-trans Due to (or as a consequence of) D.0.D. Division of Vital Records, P.O. Box 68760 ate has been signed by the attending p page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Year Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yolanda 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deaty?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Nachesney Mary examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 D Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: al or Attending P s after death. I Director: After t 1 Natural injury work 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determi*n*ed Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D 63420 November 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Bel Air, MD, 21014 upper Chesapeake Dr 31. Date filed (Month, Day 32. Registrar's Sign ture State DEC Registrar

DHMH 17 Rev 7/2009

To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 Division of Vital Records, within 24 hours after de

To the Funeral Directo

completed filled in by th

Baltimore, Maryland 21215-0036

esuiting in death)	Due to (or as a consequence of):							
No. 11 11 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Hypertension							
Sequentially list conditions, fany, leading to immediate	Due to (or as a consequence of):							
cause. Enter Underlying Cause (Disease or iinjury	Atrial Fibrillation	n						
hat initiated events esulting in death) Last	Due to (or as a consequence of):							
	Urosepsis							
FEMALE: 3b. Was decedent pregnant in the past 12_months? 1 ☐ Yes 2 ☑ No g ☐ Unknown	23c. If yes, outcome of pregnancy 1	opic pregnancy er (specify)	23d. Date of do Month	f delivery Day Year				
art II. Other significant condition	ons contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobacco use contribute t	the cause of death?				
	Peptic Ulcer Disease, Chi		1 Yes 2 No 3 I	2 No 3 Probably 4 🕅 Unknown				
	lmonary Disease, Solitar	y Kidney Acute	autopsy prior to	utopsy findings available completion of cause of				
Renal Failure				s 2 No				
5. Was case referred to medical examiner? 1 X Yes 2 No	Hospital:	26. Place of Death (Check of D						
1 LAYes 2 L No 7. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatient 3	UDA 4 LI Nursing Hom	e 5 K Residence 6 Other (Spe	cify)				
Manner of Death Matural 5 □ Pendir Q □ Accident Investi	g (Month, Day, Year) injury	work?	d. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		actory, office 26	Bf. Location (Street and Number or R City or Town, State)	and Number or Rural Route Number, ate)				
(Check 2 Medical I	Physician: To the best of my knowledge, death occure xaminer: On the basis of examination and/or investigation Nurse Practioner: To the best of my knowledge, death	n, in my opinion, death occurred at the	ne time, date and place, and due to the	cause(s) and manner stated				
9b. Signature and title of certifie		29c. License number	29d. Date signed (Mon					
inex	ca Bali	D0059994	11/30	2/U				
O. Name and address of person Monica Bali, I	who completed cause of death (Item 23a) (Type, Print) 1.D. 13975 Connecticut A	venue, #308, Sil	ver Spring, Mary	land 20906				
1. Date filed (Month, Day, Year)	2011 Le Registrar's Signature Aserta	,						
	ORIGINAL							

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 28, 2011 2:33 A Donald William Moore, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Hospice Casey House Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 579-34-7190 **Director** 81 1 XM 2 □ F January 12, 1930 Washington, D.C Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6117 Calwood Way 20852 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 1948-Black, White, etc ö 1 Never Married 2 Married þ Maryland 21215-0036 nours after Specify: White 1 ☐ Yes 2 X No Specify: If Yes Give "natural", 1950 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Assistant Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of Donald William Moore Elizabeth Lovett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 6117 Calwood Way, Rockville, Maryland 20852 Charlotte R. Moore/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 3, Park pawn Memorial 1 Burial 2 Cremation 3 Removal from State injury or 2011 Rockville, Maryland 4 Donation 5 X Other (Specify) Entombrent 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Signature of Funeral Service License any i R88kville; Inc. 300 West Montgomery Avenue M01498 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final Physician/ Coronary Atherosclerosis disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 the IF FEMALE: use yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Dav Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy performed' 1 Yes 2 No certificate 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospice Inpatient
6 🛛 Other (Specify) Other: 4 Nursing Home 5 Residence Hospital 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d Describe how injury occurred After iniury 1 XNatural 5 Pending thin 24 hours after death.

the Funeral Director: Ai
mpletely filled in by the fu 1 Yes 2 No death. Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the within To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) November 28, 2011 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1,3x,

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

MD

Geoffrey Coleman,

DHMH 17 Rev 06-2011

1355 Piccard Drive, #100, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38480 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ERICA LESLIE MARANTZ NOVEMBER 30, 2011 12:40 PM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 573 KIRKCALDY WAY ABINGDON HARFORD Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 067-32-0437 69 Director 1 □ M 2 🕅 F NY Yrs 03/22/1942 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State death with the Maryland 10b. County 10d. Inside City Limits Director notified NJBERGEN FAIR LAWN 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 5-41 BRENNAN COURT 07410 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 21 If Yes, Give Year or Dates filed within 72 hours after 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 5+ ASSISTANT PRINCIPAL EDUCATION other traumatic event, Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental h မ DAVID ELIAS BLANCHE STOLBACH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 KIRA LURMAN / DAUGHTER 573 KIRKCALDY WAY ABINGDON, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 0 🗌 Burial 2 🗌 Cremation 3 💢 Removal from State permit. Page Department of Important: If any injury or 12/01/2011 4 ☐ Donation 5 ☐ Other (Specify) HEBRON CEMETERY FLUSHING, NY 22. Name and Address of Facility 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of each line Immediate Cause (Final ncer Physician/ mauch disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other 1 🗌 Yes 2 4 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Director: After (Month, Day, Year) 1 Natural 5 Pending work? 2 No □ Accident Investigation filled in by the Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar HMH 17 Rev 06-2011

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

500 upperchesapeake

MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Josephine 26 7:00 PM Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 2 Country) 103 Director 073-16-6494 Puerto Rico 1908 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Rockville 1 X Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 USA 6121 Montrose Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1™ Yes 2□No SpecifyPuerto Rican If Yes, Give 3 ₺ Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Garment Worker Garment Be traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event ၉ Alejandrina Cruz Paulino Pamias 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11345 Empire Lane Rockville, MD Louis Nunez - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Raymond Cemetery 12 - 2 - 11Bronx, New York Thomas C. Montera Funeral Home of Funeral Service Licensee 22. Name and Address of Facility 10472 Bronx, NY 1848 Westchester Ave (art of Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical Dementin disease or condition resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): as the burial-transit Gause (Disease or impury that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE Live Birth 2 Fetal death use 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔏 No
9 ☐ Unknown Month be detached for Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 K No death? 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 🗌 Yes 2 📈 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 NUN JOSEPHINE

within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should

27. Manner of Death

1 X Natural

3 Suicide

29a. Certifier

Accident

5 Pending

Investigation

determined

6 Could not be

Certificate:

Hospital

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0064871 mina 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rol MD Rockville

28a. Date of injury (Month, Day, Year)

montrose 6121 azli

State Registrar 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

28c. Injury at

1 Kartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

City or Town, State)

28f. Location (Street and Number or Rural Route Number,

11-28-2011

20852

Please Type or Print in Black Indelible ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38482 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death November 27. Physician/ Mary D. Nordhoff 2011 1:30 p. Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Oak Crest Care Center Baltimore 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** Months Days Hours 1 M 2 XX JUneth 201, 1921 MaryTand 218-12-7489 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Funeral Director Maryland Baltimore Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 8810 Walther Boulevard #3421 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc o. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: "natural", 3 X Widowed 4 □ Divorced traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marion J. Pittinger Mary Regina Rathgaber 19a. Informant's Name/Relationehio (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 8559 Harris Avenue Baltimore Maryland 21234 Robert J. Pittinger/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 12/1/11 Baltimore Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, I 5305 Harford Road Thc. Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ SCUD disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No Day 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? F. beilla Fien 24a. Was an autonsv performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: '24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) monios D58646 25, 2011 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Morring wa It has Paulcoille MA Benjevard 8500 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 0^{Day} Physician/ NOV. 2019 9:21p M Dorothy O. Perkins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of L ath **Examiner** Gilchrist Center Towson Baltimore ocial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days (Month, Day, Year) 214-44-2767 **Director** 1 M 2 DXF 72 Maryland July16,1939 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 1351 Clinton Street 21224 USA death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. or þ 1 Never Married 2 Married Yes 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White Specify Completed 3 Widowed 4 XDivorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Tavern 6th Bar Maid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) And the control of th Mental F ဂ္ Arthur Perkins Dorothy N. Hewitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) April Perkins /niece 348 Maple Avenue Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Gardens of Faith 12/3/11 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Lic. see 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each like. 23a. Part 1. Enter the disease, or Q Approximate Interval Between shock, or heart failure. List on Immediate Cause (Final Onset and Death Physician Ve NGOSTI PARS disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions, if any congression of the cause. Enter Underlying Cause (Disease or injury that initiated events Examine and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregname 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 mon Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ENDSTAGE RENAL DISCASE Hospital or Attending Physician: The law requires t 1 Yes 2 No 3 Probably 4 Unknown 2 DIABETES MELLITUS Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy CHRONIC OBSTRUCTIVE PULMONARY DISPAGE Yes 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 105PC 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 ☐ Yes 2 ☐ No Natural 5 Pending М Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death account at the time. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number d address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ P^{M} Robert Adalbert Preisendorfer 4:15 November 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Brightview Assisted Living Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Month, Day, Yea 89 216-16-6434 1921Bethlehem, **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Baltimore 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2824 Alvarado Square 21234 items 23a United States Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White WWII 1 Yes 2 XNo Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel and Mental Hygiene. Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adalbert George Preisendorfer Jessica Severance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Helen Preisendorfer-Wife 2824 Alvarado Square Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December Dulaney crematory or ether place)
Dulaney Valley
Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State Timonium, Maryland 4 Donation 5 Other (Specify) 2, 2011 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services Parkville
8800 Harford Road, Parkville, Maryland 21234 Plart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Imprediate Cause (Final disease or condition Onset and Death Physician/ Vascale den Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to increase cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Dire to (or as a donsequence or) Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Dav Pregnant at time of death Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? HBE 24a Was an s certificate has the director, page 2 s performed 12 C. P 2 No 1 Yes Division of Vital 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Hospital: Other: 은 1 🗌 Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Natural Natural 5 Pending Accident Investigation Suicide 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined Hospital 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completed fil 29b. Signature and title of certifie 29c. License number 033333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6,5 W. MACPHA 5 200

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 38485 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 29, 2011 James George Piluk 2:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 X M 2 ☐ F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 5-10-1924 Maryland **Director** 218-12-2549 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ner must be notified 1 Yes 2 XX MDHarford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 610 Mountain Road 21047 US 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or ite Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 🛪o Specify. Specify: 3 X Widowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Stock Chaser General Motors Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 Frank Μ. Piluk Mary Giza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie S. Hill (daughter) 2003 Tiffany Terrace, Forest Hill, MD ξ Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Bacred Hrt Jesus Cem 112/2/2011 4 ☐ Ponation 5 ☐ Other (Specify) Dundalk, MD 21. Sign to re of Fundral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Bel Air 610 West MacPhail Road, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death END STOGE RENAL DISEBSE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner UREMIA Sequentially list conditions, if any conditions in models cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine ATRIAL FIBRILLATION Due to (or as a consequence of) resulting in death) Last Physician/Medical B IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Napatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Division 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D71096 November 29, 2011 Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANGELIA ESPOILLA 520 Upper Chesapeales Dr. 31. Date filed (Month, Day, Year)
DEC 0 2 2011 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marshall Prankard Powel1 November 29, 2011 9:00 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 579-38-5989 1 X M 2 □ F **Director** 86 May 10, 1925 Washington, D.C. Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? ò ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be injury or other traumatic. Funeral 13404 Valley Drive 20850 United States 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. 1 and 2 should be filed within 7 f Health and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Self Employed Real Estate Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Lester Beasley Powell Alice Prankard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara S. Powell /Wife 13404 Valley Drive, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth December cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6, 2011 Resthaven Memorial Gardens 4 Donation 5 Other (Specify) Frederick, Maryland 21. Signature of Funer / ervice Licensee Röbert A. Africa Tumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Manteller M01305 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Subdural Hemorrhage disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Seizure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Fall To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) 2 nding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 1 X Yes 2 🔲 No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year)
Nov. 8, 2011 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 🗶 No Natural 12:14 PM Fall X Accident Investigation within 24 hours after death

To the Funeral Director: A
completely filled in by the i 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
At Home 28f. Location (Street and Number or Rural Route Number, determined 13404 Valley Dr. Silver Spring, MD Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29h. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

971)

Registrar

DHMH 17 Rev 06-2011

State

8600 Old Georgetown Road, Bethesda, Maryland 20814

who completed cause of death (Item 23a) (Type, Print)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Barbara Poltorak November 2011 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5113 Viking Road Bethesda Montgomery 8. Date of Birth (Month, Day, Yea June 18, Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Yrs. Poland **Director** 218-23-3899 59 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Tyes 2 X No Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5113 Viking Road 20814 United States within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
item 27 is marked other than "natural", or i þ 2 X No 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Physician Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Leszek Misiewicz Anna Wisniewska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Maciej Poltorak / Husband 5113 Viking Road, Bethesda, Maryland 20814 Gate of Heaven
Mausoleum 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State December 10, 4 Donation 5 X Other (Specify) Entombment 2011 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Note of A. A. Pumphrey Funeral Home/Bethesda—Chevy Chase Inc. this far 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phymician/ Encephalopathy disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Brain Abscess Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) the burial-transit Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Pregnant at time of death 5 Other (specify) Day Year as been signed by the 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 💢 No Other: 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred XNatural 5 Pending injury within 24 hours after death. To the Funeral Director; A М 1 🗌 Yes 2 No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office filled in by determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 1 (okan November 29, 2011 D37142

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Geoffrey Coleman, M.D. 1355 Piccard Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-08846

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James Peterkin State of Maryland / Department of Health and Mental Hygiene 38488 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month November 23, 2011 2059 hrs Madical Examiner Peterkin James Α. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Carroll Carroll Hospital Center Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Foreian Months Hours 213-90-4177 Director Country) 1 x M 2 F Yrs 39 Feb.7,1972 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 No s 23a or 28a-f show e notified at once, 28a-f shov MD Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. rector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2768 Fenwick Ave. 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funeral 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married 2 X No 1 Yes if Yes, Give Year Specify: Black 3 Widowed 4 × Divorced 1 Yes 2 No specify: <u>≨</u> or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Laborer Construction 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brenda Fave Peterkin Willie Anderson ^{19a.} Informant's Name/Relationship (Type, Print) (sister)
Antonia Faye Hampton-Hicks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2768 Fenwick Ave. Balto, Md. 21218 Date 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Dec.2,20 crematory or other place 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory Balto, Md. Donation 5 Other Specify 22 Name and Address of Facility
Calvin B. Scruggs Funeral Home 21 Signature of Funeral Service License Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Modical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transil per me,8922 12-6-11 sm -8-11 sm Physician/Medical AMENDED 23a, pt. II , 27 17, per fh, g922 12-■ UNPENDED The law requires that the death certificate be Box 68760. 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown is been signed by the att should be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ₫ 1 Yes 2 No 3 Probably 4 V Unknown Diabetes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? performed director, page 2 1 ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Other, Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 2 No 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending neral Director: hours after death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be .dn 24 hours.
.o the Funeral Decompletely fille. or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. November 24, 2011 30. Name and address of person who completed oduse of death (Item 23a) Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Jack Titus MD.

State Registra

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38489 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Carol J. Ouintana 4:28P M 29 201 NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. 8. Date of Birth **Funeral** 1 □ M 2 🛛 F 69 Months Davs Hours Nov. 14, 1942 235-64-8957 WVA Director Usual Residence of Decedent Show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Funeral Director Nottingham Baltimore MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 7942 Belridge Road USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married White If Yes, Give 1 Yes 2X No Specify: Specify: Completed 3 Widowed 4 XDivorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Doctor's Office Billing 2yrs Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental H Item 27 is marked ot ျှ Lucille Perkins Clarence T. Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 7942 Belridge Road Nottingham MD 21236 Alex Quintana /son Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date Bayview Crematory 1 Burial 2 X Cremation 3 Removal from State 12/5/11 Baltimore MD 4 Donation 5 Other (Specify) balto. MD 22. Name and Address of Facility 300 Mace Ave. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** Medical resulting in death) D o (or as a consequence of): Examiner Sequentially list conditions Examine to (or as a consequence of): ir any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit EntenSIO cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 2 No prior to completion of cause of death?
1 ☐ Yes 2 No this certificate completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 🗌 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending 1 💇 Natural 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

within 24 hours after death. To the Funeral Director: After Hospital

> State Registrar

(Check only one 29b. Signature and title of certifie

William

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Orunhin

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20657

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G923, 1730/2012, WS

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2 Day RICHARDSON 13:44 PM WILLIAM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMERY OLNEY MONTGOMERY GENERAL HOSPITAL 5. Social Security Number 8. Sex 1 M 2 D F . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. Country) 579-72-6132 57 Director DC Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Yos 2 🗌 No DC Washington 10e Street and Number 10f. Zip Code 0 10g. Citizen of What Country? "natural", or items 23a or Funeral USA 1459 S Street NW 20009 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: Specify: Completed 3 Widowed 4 Divorced Black Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 Years Elementary/Seconday (0-12) and Mental Hygiene. Printer Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William A. Richardson, Sr. permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Lillie Mae Robinson 192 Informant's Name/Relationship (Type, Print) / Wife Sherrion Ruff-Richardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 Florida Ave. NW Washington, DC 20001 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🎽 Cremation 3 ☐ Removal from State 12/5/2011 | Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Fun al Service Licensee 3831 Georgia Ave. NW Washington.DC cc0278 20011 23a. Part N Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARRHYTHMIA disease or condition *Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Vear Pregnant at time of death Ves 2 No ed by the a g Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Were autopsy findings available prior to completion of cause of 24a. Was an has autonsv page 2 death? 1 Yes 2 No certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examine? Hospital Other: 2 🗆 No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending after death. ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 8 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a, Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00070224 11,21,2011 less of person who completed cause of death (Item 23a) (Type, Print) UASON ADLER 18101 Prince Phillip Dr. Olney, MD 20832 31. Date filed (Month, Day, Year) State 2 2011 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	kecute n and al-trans	Exar									+					
09/	cate be executed physician and s the burial-transit	edical		d												
6876	5 40		IF FEMALE:	00 11					· · · · · · · · · · · · · · · · · · ·			1				
Вох	Attending Physician; The law requires that the death certifics sr death. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnan 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 5 Other (specify) 23c. If yes, outcome of pregnancy									23d. Date of delivery Month Day Yes			,	
ds, P.O.	v requires that to been signed book should be deta	þ	Part II. Other significant conditions of	contributing to death I	out not resu	ulting in the u	nderlying cau	se given	in Part I.		23e. Did to		_		e cause of death?	
Division of Vital Records,	. The law re cate has be , page 2 sh	Completed									24a. Was a autop perfor 1 Yes	sy rmed?	pi de	lere autoprior to coreath?	osy findings available inpletion of cause of 2 Mo	
ital	ysician: The is certificate director, paç) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No	Hospital:		55 /0:	_	Other:	of Death				- X Z		HOCRECE	
on of V	al or Attending Phys s after death. I Director, After this ed in by the funeral d	icate: To	27. Manner of Death 1 Natural 2 Accident Investigatio	28a. Date of inju (Month, Da	iry	ER/Outpatien 28b. Time of injury		Injury at work?		28	ie 5 ⊔ Resid 3d. Describe h				HOSPICE	
Divisio	tal or Attens after der all Director ed in by the	Il Certificate:	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At hor c. (Specify)	me, farm, stre	et, factory, of	fice		2	Bf. Location (S City or Tow			or Rural	Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in	Medical	(Check 2 Medical Examonly one) 3 Certifying Nur	rsician: To the best of niner: On the basis of e se Practitioner: To the	examination	and/or invest	igation, in my	opinion, o	death occ	urred at t	ne time, date a	nd place	e, and due	to the cau	ise(s) and manner stated.	
	Norith Co.		29b. Signature and title of ceptifier	SCANT			29c. Li	214	umber 191	92		29d. Da	ite signed	ZOI	Day, Year)	
F	[30. Name and address of person who					, · · ·	ψτων	MITIM	, MD 2	1003	1 /			
	Stat	e	JACKIE JONES, C 31. Date filed (Month, Day, Year)		ar's agnati	NEY VA	LLCI K	υ•	TIMU	MLUM	, MU Z	TOA				
	Registra	ar	DEC 0 2 2011	Chew	P. 17	4										

DHMH 17 Rev 06-2011

NOVEMBER 29, 2011 12:30 a.m.

GEORGE RILEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 27^{Day} 2011 Physician/ Jean C. Revell 18:53 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rebecca House Potomac Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) **Illinois** 8. Date of Birth Month, Day, 1 🗆 M 2 🗶 F Months Year 914 Days Hours 96 **Director** 328-14-3292 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland Montgomery 1 Yes 2 X No Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 2. by Funeral 11400 S. Glen Road 20854 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. ö 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. "natural" 3 X Widowed 4 ☐ Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Physician Medicine Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked of r other traumatic ever ၉ Page 1 and 2 should be Robert Morton Lulu McFarland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Carole Ottesen/Daughter 11400 S. Glen Road, Potomac, Maryland 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State December 2 Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Humboldt, Iowa 2011 . Signature of Funeral Service Lir enge 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 suen M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Hypothyroidism Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami Alzheimer's Dementia and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending place as as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available nas autopsy prior to completion of cause of death? certificate ha performed?

1 Yes 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yeş 2 **X** No Other: ည this 1 Inpatient 2 ER/Outpatient 3 DOA \square Nursing Home 5 \square Residence 6 $ot\!\!X$ Other (Specify) $\operatorname{Asst.}$ $\operatorname{Liv.}$ 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🗶 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: Afortpleted filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I

comple Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Pdu D41162 November 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Doctors Drive, Germantown, Maryland Vinu Ganti, M.D. 20874 Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carol Murdock Scinto November 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 807 W. Edmonston Dr. Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Days 1 M 2 X F Director 85 Washington 542-22-1298 Dec. 16. Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Rockville 1 X Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 807 W. Edmonston Dr. 20852 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Race - American Indian ō Black, White, etc. ould be filed within 72 hours after oud Mental Hygiene.

marked other than "natural", or þ 1 Never Married 2 Married ☐ Yes 2**X** No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Murdock Florence Blythe and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Joseph Scinto / Husband 807 W. Edmonston Dr., Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 and Department of Hall Important: If ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Chesapeake Crematory 12/02/2011 Beltsville, MD 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ LIVER CANCER disease or condition YEARS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnarl-transit Cause (Disease of it that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate; 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

ADIN T.



29c. License number MD33037

DECEMBER 1, 2011

20006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Martha line 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Montonery

9. Birthplace (State or Foreign Rockville 8. Date of Birth (Month, Day, Sept 23 1 □ M 2 🕱 F Months Hours Min 1922 Washington DC

20902

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Sept

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2715 Emmet Road Silver Spring, MD 20902

Date

Sadie Rosen

10d. Inside City Limits 1 Yes 2X No

10g. Citizen of What Country?

14. Race - American Indian.

white

Black, White, etc.

jewelry

20c. Location - City or Town, State

11-21-2011

USA

Specify:

16b. Kind of Business Industry

Physician/ Medical Examiner For State Registrar

Usual Residence of Decedent

10e. Street and Number

11. Marital Status

Montgomery

15. Decedent's Education (Specify only highest grade completed)

1 Burial 2 Cremation 3 Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

6121 Montrose

Registrar's Sign

Fazli,

31. Date filed (Mo

5 D Other (Specify)

12. Was Decedent Ever in U.S.

Was Decedent _vo. Armed Forces? 1 ☐ Yes 2 💢 No

College (1-4 or 5+)

If Yes, Give Year or Dates

11901 Georgia Avenue

1 Never Married 2 Married

3 X Widowed 4 ☐ Divorced

Elementary/Seconday (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

Joel Sattler/son

Jack Fink

20a. Method of Disposition

4 X Donation

10a. State

Director

Funeral

Completed by

Be

ည

Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/) Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Division of Vital Records, P.O. Box 68760 signed by ti s certificate has t lirector, page 2 s Medical Certificate: To this filled in by the funeral after death. within 24 hours af

To the Funeral D

completed filled in

	21. Signatur of Funeral sice Licen	Firector	Stan	reand Andrew of Fycili Boar	rd 655	W. B.	altimore	Street	Ī
	Janvilla	le -		timore, MD 21					
	23a. Aart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final disease or condition esulting in death) a. Due to (or as a consequence of):								
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of): d		_					
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of death 1 Live Birth 2 Fetal death 5 Other (specify) Month 9 Unknown 9 Unknow								
leted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
Comp					pe	copsy formed?	prior to death?	topsy findings available completion of cause of	
Be	25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)				7
ပ္	T La Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	tient 3	DOA Other: 4 X Nursing F	lome 5 🗆 Re	sidence	6 Other (Speci	ifv)	
Medical Certificate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			28c. Injury at work?	28d. Describe				
al Cert	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, fac	ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Medic	only one) 3 Certifying Nurs	ician: To the best of my knowledge, dea ner: On the basis of examination and/or in e Practioner: To the best of my knowledg	estigation/	in my opinion, death occurred	at the time date	and place	a and due to the c	cause(s) and manner state	d.
	29b. Signature and title of certifier			29c. License number			ate signed (Month		-
	mina farl'		D0064871	11	11-21-2011				

10c. City, Town or Location

Wheaton

20b. Place of Disposition (Name of cemetery, crematory or other place)

10f. Zip Code

16a, Decedent's Usual Occupation

salesperson

1 ☐ Yes 2 X No Specify:

(Give kind of work done during most of working life. DO NOT use retired)

State Registrar

To the I

并

Rd

Rockville

MD

20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Montal Hygiene 23aPt1,28a-f per me, g922,12702/201 Montal Hygiene Certificate of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month A^M 3:47 Henry В. Scott October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** George's Hospita Prince George's Lever Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 213-32-2529 Director 1 X M 2 □ F 75 Feb. 19, 1936 Virginia Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f Middlesex 1 Yes 2 X No Virginia Saluda 10e. Street and Numbe 10f. Zip Code 9 10g. Citizen of What Country? 23a 366 Seven Springs Lane U.S.A. 23149 permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 M Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Lumber Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Holiday L. Scott Mattie K. Harris and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Evelyn Mathis (Daughter) PO Box 204, Ark, VA 23003 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important; If it any injury or o 1 X Burja 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Immanue1 Baptist Church 11/4/2011 Saluda, VA Signature of Fun ral Service Licentee 22 Name and Address of Facility J.K. Redmond Funeral Home P.O. Box 266, Shacklefords, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ea h line. **Multiple Injuries with Complications** Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and Due to (or as a consequence of): use as the burialattending physician HOO. Physician/Medical certificate be IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Fregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day be detached the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Was an has page 2 autonsv performed? Yes 2 No death? Director: After this certificate 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 2 Inpatient 2 ER/Outpatient 3 DOA funeral (27. Manner of Death 28d. Describe how injury occurred Subject driver of a truck struck fixed 28a. Date of injury 28b. Time of 28c. Injury at Certificate: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural
2 Accider 5 Pending 10/17/2011 4:17a. M Yes 2 No Accident Investigation object. 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Aller Cang 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as seted. 29a. Certifier The continuing Frystician: to the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sixted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sixted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sixted.

| Continuing Frystician: | On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sixted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0042183 11/01/2011 Ka ZOOL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Carlo

DHMH 17 Rev 06-2011

Please Type of Printin Black Indelible 11/1/2 Insura All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:50AM 201 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death of MD Court OWSON OWSON imor P 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Months Min BALTIMORE, MI Director 10a. State 10b. County aţ 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f BALTIMORE 1 🗆 Yes 2 💢 No 10e. Street and Number 'n 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Completed by Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 21093 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. med Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) BROKER Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 ker-da 20b Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 2011 BALTIMORE NO 21. Signature of Funeral Service L 6924 YORKRD, MONKTON MD21111 Emations Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas shock, or heart failure. I ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any. leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to or as a consequence of Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 🗔 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag performed 1 🗌 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Assisted 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CRND WSK 069 31. Date filed (Month, Day, Year, 0 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38498 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ November 28, 2011 Arlene Shapiro 11:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4701 Willard Avenue #236 Chevy Chase Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 3, 1926 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days New York Director 079-20-5570 1 🗆 M 2 🔀 F 85 ms 23a or 28a-f show must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4701 Willard Avenue #236 20815 USA ral", or items ? Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Yes 2X No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Economist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Archibald H. Kurland Estelle Polstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sidney Shapiro/husband 4701 Willard Ave. #236 Chevy Chase, MD 20815 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crematory 12/01/11 4 Donation 5 Other (Specify) Woodbine, MD 21. Signatur of Funeral Service Lice 22. Name and Address of Facility
Sing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Dementia Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of). cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 2X No 1 ☐ Yes 2 ₽ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Stage 3 Chronic Renal Disease certificate has perform 2 No Yes 2 X No 1 🗌 Yes or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?
1 Yes 2X No Hospital Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Contifying Nurse Practitioner: To the best of my knowledge, death construct or the time, date and place, and due to the name as and manner as stati-29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39947 November 30, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mona Ellis, M.D. 5530 Wisconsin Ave. #645 Chevy Chase, MD 20815

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Phyllis Landa Singerman Medical November 2011 5:28 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3112 Gracefield Road #515 Silver Spring Montgomery 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 1 - M 2 X F Days Hours (Month, Day, Ye **Director** 055-24-5894 84 New York 8 Oct Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits 28a-f 1 ☐ Yes 2X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3112 Gracefield Road #515 20904 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. ò 1 Never Married 2 Married δ Yes 2X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72.1 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Social Services Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Landa Rose Miller other traumatic 1 and 2 should be if Health and Meritem 27 is market 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Singerman/son 161 W. 54th Street #1403 New York, New Yory 10019 Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or off 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Final Journey Crematory 12/01/11 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Coing Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Metastatic Lung Cancer months Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami Cause (Disease or linjury sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be as the t attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b, Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) Month Year Day 9 Unknown detached 9 Unknown P.O. | signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Pulmonary Disease Completed 1X Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 2 🗌 No Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 X No Hospital: Other: 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🕅 Natural 5 Pending injury Accident Investigation

Division of Vital Records, To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director; I

State Registrar

Medical

3 Suicide

29a Certifier

(Check only one) 6 Could not be

determined

Mark Parkhurst, Silver Spring, MD 20904 31. Date filed (Month Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3110 Gracefield Rd.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D24093

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

November 30, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 38500 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 29, 2011 Jesus Μ. Silva 7:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Manth, Day, Sept 2, 9. Birthplace (State or Foreign **Funeral** Days Hours 217-39-6307 1930 **Director** 81 Colombia 1 XM 2 □ F Page 1 and 2 should be filed within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11477 Applegrath Way 20876 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No "natural", or item edical Examiner r Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ρ 1 Never Married 2 X Married Yes Yes, Give Baltimore, Maryland 21215-0036 1X Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates Colombian f Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Builder Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Luis Alejandro Silva Ana Sofia Pineros 19a. Informant's Name/Relationship (Type, Print) Luisa C. Silva/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11477 Applegrath Way Germantown, MD 20876 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/02/11 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 51251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029
death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
Approximate MO1251 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Dav Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b page 2 autopsy nerform death? 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗆 Yes 2 **X**No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No filled in by the Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 ___, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signaturş 29c. License number 29d. Date signed (Month, Day, Year) R143201 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller CRNP 6001 Muncaster Mill Rd. Rockville, MD 20855

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

DEC 0 2 2011